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An Assessment of the Ambulatory Care User Fee Systems In Ministry of Health Facilities of Honduras

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Abstract

In 1989, the Ministry of Health of Honduras passed *The Regulation and Manual for Recovered Funds* (RMRF) establishing a national user fee policy. The RMRF provides a detailed framework of rules and regulations, and decentralizes its administration to the regional offices. It also allowed for communities to develop a community health board (CHB) and to establish a community user fee system (CUFS), which the CHB would administer, in lieu of the system administered by the regional offices (the latter being known as an institutional user fee system (IUFS). The RMRF never specified any other requirements for CHBs or CUFSs, and in the decade since the law's passage, there has developed an unknown number and wide variety of CUFSs, in terms of structure, operations and fee levels. The *RMRF* also established specific levels of user fee charges and several restrictions that are all expressed in specific, nominal Lempira-denominated amounts. By 1999, inflation had eroded the real value of these levels to 21 percent of what they were in 1990, and they had come to impose an ever-increasing administrative burden and cost on MOH facilities, undermining incentives for collecting the fees and encouraging non-compliance.

A survey conducted under the auspices of this study produced the first inventory identifying the number and type of UFS in each of the MOH's 1,128 facilities, as well as detailed information about their price levels, exemption policies revenues, expenditures, administrative systems, and the opinions of facility and regional office staff and municipal government officials about the systems. One fifth of MOH facilities do not have a UFS. Forty-three percent have a CUFS, 26 percent have an IUFS and 10 percent have a combination of the two types. User fee levels in both systems are low. A general consultation's price averages 2.0 lempiras in IUFSs and 3.1 in CUFSs. Average IUFS prices vary across different types of facilities in such a way that it encourages would-be patients to use the pyramidal referral system inappropriately. Average fee levels in a health post are higher than in a health center, and they are lowest in the national hospitals. The likelihood of paying for an ambulatory acute care visit is highest at a health post, 89 percent, and lowest at a hospital, 49 percent. These fee levels and exemption practices encourage the inefficiency of the MOH.

As a cost recovery/income generating mechanism, user fees have always played, at best, modest role. Revenues have remained constant at a mere two percent of the total Central Government-funded MOH expenditures for a decade. The systems' administrative costs, estimated at 23 million lempiras in 1999 were the equivalent of 67 percent of their revenues. While the net revenues of national and regional hospitals IUFSs are positive, that of the regions (area hospitals, health centers and posts) is negative. Elimination of the IUFSs in the regions would actually save the MOH money and/or enable its facilities to provide more care.

The surveys revealed that the key issue is not whether or not there should be user fees, but rather, how the systems can be made to function more effectively. There is an urgent and growing need to reform the RMRF so as to enable the restructuring and reinvigoration of these systems. Fee levels need to be increased, and the systems need to be made more formal, with more explicitly established operating goals, rules and procedures so that they are more effective in recovering costs and encouraging community participation in a manner that obviates conflict, promotes transparency, and yet protects the resources, operations and integrity of the local health facility's operations and the operations of the entire MOH.

Two sets of recommendations are proffered. One set addresses shortcomings of the *RMRF*. A second calls for convoking a working group to consider a more ambitious agenda, which aims to integrate the Ministry of Health more fully into the Government of Honduras' general decentralization initiative by devolving oversight of the UFS to municipal governments. The devolution proposal is highly flexible and serves the present and future needs of both the Ministry of Health and Honduran society.

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Acronyms

AMHON	*Asociación de Municipios de Honduras* (Honduran Association of Municipal Government)
CESAMO	*Centro de Salud con Médico y Otros* (Health Center with Physician and Others)
CESAR	*Centro de Salud-Rural* (Rural Health Center)
CPI	Consumer Price Index
CS	Community System (community user fee system)
CUFS	Community User Fee System
ENIGH	*Encuesta Nacional de Ingresos y Gastos de Hogares* (National Survey of Household Income and Expenditures)
GOH	Government of Honduras
IS	Institutional System (institutional user fee system)
IUFS	Institutional User Fee System
MOF	Ministry of Finance
MOH	Ministry of Health
PHR	Partnerships for Health Reform Project (USAID)
RFRM	Regulation and Manual for Recovered Funds
RO	Regional Office
UF	User Fee
UFR	User Fee Revenue
UFS	User Fee System
UPS	*Unidad Productora de Salud* (Health Facility)
USAID	United States Agency for International Development

Executive Summary

User fees have been charged in some Honduran Ministry of Health (MOH) facilities since the 1950s, shortly after the MOH was established. The first fee systems were specific to individual facilities, and it was not until 1990 that a comprehensive national user fee policy, *The Regulation and Manual for Recovered Funds* (RMRF), was enacted. The RMFM, which still embodies the Government of Honduras' (GOH) official user fee policy and constitutes the ultimate authority on user fees in MOH facilities, sets forth the rules and regulations governing their structure and operations. It provides a detailed framework of rules, regulations, and reporting requirements, and identifies and assigns specific management, accounting, and supervisory responsibilities to specific MOH positions or designees.

The RFRM states that "all MOH facilities… will charge the established tariff for services that are provided to the public" (page 10). It provides very specific guidance with respect to the levels of user fees and some charging practices. For instance, it:

- identifies six health services that are to be provided free-of-charge—immunization, prenatal care, growth and development, family planning, and treatment of tuberculosis and of sexually transmitted diseases;

- identifies categories of patients who should be provided care at reduced fees, or entirely free-of-charge – the poor and active community health personnel; and,

- establishes specific prices, which vary by type of facility, for specific services.

In addition, the *Regulation* states that user fee levels "will be revised periodically" (page 10) by the individual National, Regional, and Area Hospitals and CESAMOs (*Centro de Salud con Médico y Otros*, Health Center with Physician and Others) with "pre-approval of the Central Level and in agreement with the level of care provided and the socio-economic situation of the community" (page 5).

The RFRM also establishes some very specific rules regulating the use of the revenues generated, including:

- revenues must be deposited in a State-owned bank account;

- facilities may establish a rotating fund, but the maximum amount of money that the fund is allowed to contain is 2,000 lempiras;

- to make purchases in excess of 100 lempiras, at least three price quotes must be obtained;

- facilities are prohibited from spending their revenues on personnel; and,

- for purchases of medicines in excess of 1,500 lempiras, a quote must be obtained from the MOH Central Medicine Stores.

The FRM contains no provisions for modifying these regulations.

The RMRF also allows for the development of another user fee system, one that is operated and controlled by the "community." The official MOH system therefore, is known as the "institutional system" (IS), while the new system is referred to as the "community system" (CS). Although the RMRF recognizes the legitimacy of the CSs, it does not establish any requirements, or even provide guidance about a CS's structure or operating procedures. Moreover, whereas RMRF requires these systems to be operated by a "community health board," it does not stipulate what such a board is, how it should be formed or how it should function. The CSs are not required to adhere to the RMRF, and are not required to report to, and are not monitored by, any MOH or other central government entity. By allowing for their considerably greater independence, the FRM encourages the formation of CSs. It is widely recognized that these systems have been growing in number in recent years, yet until this study there has been only anecdotal information about the number, structure, operations and financial significance of these independent, decentralized systems.

The purpose of this study is to assess the performance of the outpatient user fee systems (UFSs) of the Ministry of Health facilities.

The Number and Types of User Fee Systems

A survey conducted under the auspices of this study produced the first inventory identifying the number and type of UFS in each of the MOH's 1,128 facilities. One-fifth of MOH facilities, primarily CESARs (*Centro de Salud-Rural*, Rural health Center), do not have a UFS. Forty-three percent have a community system, 26 percent an institutional system and 10 percent have a combination of institutional and community systems, a so-called "mixed" system. The type of UFS varies systematically by type of facility. All three tiers of hospitals—national, regional and area—have exclusively ISs. Ninety percent of CESAMOs have a UFS, and about two-thirds of those, have an institutional system. Seventy-six percent of CESARs have a UFS, 75 percent of which are community systems. The hospitals have the oldest systems, and on average have been in operation for 20 years. The CESAMOs' system have been in existence half that time, while those of the CESARs are of a much more recent vintage; on average, they are five years old.

The Dual Negative Impacts of Inflation

The RFRM established a series of specific, nominal lempira-denominated regulations. (See Table ES-1.) It does not provide any procedure for modifying these restrictions, and they are still extant today. Since 1990, when the *Regulation* was enacted into law, Honduras has had an average annual rate of inflation of 22 percent. As a result, by the end of 1999, the real value of the nominal lempira-denominated values established in the regulation have fallen to 21 percent of what their real value was in 1990, and these regulations have come to impose an ever-increasing administrative burden and cost. Inflation has also eroded the value of the revenues generated. The purchasing power of a two-lempira fee established in 1990 and never subsequently changed had fallen to 43 centavos by 1999. Alternatively viewed, a two-lempira consultation fee in 1990 would have to have been increased to 9.37 lempiras in 1999 to maintain a constant real price for a consultation. Most (51 percent) of UFSs never changed their fee levels from 1990 to 1999, and as a result experienced the full dual negative impacts of inflation over this era. Even among the roughly one-half of the surveyed facilities that have increased their fee levels at least once, the last one did so three years ago. If a facility raised its fee level to three lempiras three years ago, and thereafter did not modify it, by 1999 the real value of that fee was 1.96 lempiras. Constant or rarely changing user fee levels coupled with substantial inflation result in falling levels of cost recovery, as fewer goods or services can be purchased with the user fee revenues.

Table ES-1: *Regulation and Manual for Recovered Fund:* The Increasing Administrative Burden of Nominal Lempira-Denominated Regulations

RFRM Regulation	As Established in the RFRM in 1990	Equivalent Current Real Value (Year End 1999)
1. Maximum Amount of User Fee Revenues that Facilities May Retain in a Rotating Fund	2,500	11,725
2. Maximum Value of a Purchase of a Good or Service that Facilities May Make with their User Fee Revenues without Being Required to Obtain at Least Three Price Quotes	100	469
3. Maximum Purchase of Medicines without Being Required to Obtain a Quote from the MOH's Central Store of Medicines	1,500	7,035
4. Maximum Value of a Contract for Non-Personal Services without Being Required to Adhere to the General Accountant Office's Regulations	500	2,345

User Fee Levels (Prices) and Incentives

MOH user fee levels are low. The average institutional UFS price of a general consultation in the surveyed facilities is 2.0 lempiras, equivalent to just 0.07 percent of average per capita income. Average prices in community UFSs are significantly higher than those of institutional UFSs in both CESAMOs and CESARs, 3.40 versus 1.93 and 3.05 versus 2.21, respectively.

As already noted, half of the surveyed facilities with institutional UFSs have never changed their prices since their system was first established, on average, more than 10 years ago. Excluding the 19 percent who responded “don’t know” from the calculation, 62 percent of all of the surveyed facilities identified the regional office as an obstacle to changing their fee levels. Four of the nine regional offices stated that prices in their respective regions have never changed either because the RFRM does not permit them to change or because it is the central office that determines prices. These responses indicate ignorance about the authority and responsibility of the regional office in determining user fees, suggesting that regional offices may inadvertently be obstacles to increasing user fee levels.

On average, community UFS prices change more often and have been changed more recently than institutional UFS prices. In the 78 facilities in which institutional user fee levels were increased at least once in the past four years, a facility-specific review of service delivery statistics found no evidence that the price increases deterred utilization. Community UFSs, which are most commonly found in CESARs where care is provided by a nurse auxiliary, generally have a higher average prices than institutional UFSs, which are more commonly found in higher levels of facilities, where care is generally provided by a physician. While this study did not estimate the cost of care provision, it is highly likely that the cost of care provided by a nurse auxiliary in a CESAR with a community UFS is less expensive than that provided by a physician in a higher level of facility with an institutional system. Thus, users of CESARs are paying more for less costly care, and thus paying a higher proportion of the cost of their care than are the users of the higher levels of care. This is inequitable from a “benefits-received” perspective. Moreover, since CESARs vis-à-vis CESAMOs are generally located in more remote areas where incomes are likely to be lower, it is also likely that the incidence

of user fees is vertically inequitable; i.e., that poorer persons pay more in both absolute and relative (to income) terms.

Average institutional UFS prices vary across different types of facilities in such a way that it encourages would-be patients to use the pyramidal referral system inappropriately. Average fee levels in a CESAR are equal to the MOH average and higher than in a CESAMO, and they are higher in a CESAMO than in a national hospital. These user fee levels are providing the wrong signals to would-be patients, and encourage the inefficient use of MOH services, and thus the inefficient provision of services by the MOH.

According to data from the 1998 National Household Income and Expenditures Survey, the likelihood of paying for an ambulatory acute curative care visit at an (any) MOH facility is 79 percent. The probability is highest for persons using CESARs, 89 percent, and lowest for those using a hospital, 49 percent. Thus the relative rates at which persons are exempted from payment at the different levels of MOH care are also encouraging the inefficiency of the Ministry of Health.

The average effective price is equal to the probability of paying for care multiplied by the average price paid. Average effective prices in institutional UFSs are lowest at hospitals and highest at CESARs, encouraging the inappropriate use of the MOH's pyramidal referral system, and thereby increasing the inefficiency of the MOH. More services are demanded and provided at hospitals relative to the CESAMOs and CESARs than would be the case with a more appropriate price structure. This exacerbates congestion at the hospitals and CESAMOs and increases the costs of the MOH. This factor has probably contributed to (1) regional and area hospitals' average number of ambulatory care visits growing 47 percent faster than CESAMOs from 1995 to 1999 (22 versus 15 percent, respectively), and (2) the 35 percent increase in the share of all hospital ambulatory care that is provided in the emergency department over the same period (increasing from 23 percent in 1994-95 to 31 percent in 1997-98).

The RFRM mandates that six services be provided free-of-care:

- immunizations,
- prenatal care,
- growth and development (well-child visits),
- family planning,
- treatment of tuberculosis, and,
- treatment of sexually transmitted diseases.

While 84 percent of the surveyed facilities with institutional UFSs provide some of these services free-of-charge, only 7 percent provide all of them and thus are not in compliance with official MOH policy. There is no information with which to quantify the impact of charging for these services, but there can be no doubt that their rates of coverage and use are lower because of these violations of the RFRM. In 1999, the six services mandated to be provided free-of-charge constituted 35 percent of all ambulatory care visits provided by the MOH. It may be that facilities are more commonly charging for these services due to what they perceive to be increasing resource constraints. The proportion of total visits comprised of these MOH service priorities has remained relatively constant over the past four years, suggesting that it has not been a factor explaining changing total user fee revenues.

The Legacy of the RFRM's Ill-Defined Responsibilities

The *Regulation and Manual for Recovered Funds* calls for periodic revisions of price levels by the individual national, regional, and area hospitals and CESAMOs with "pre-approval of the Central Level and in agreement with the level of care provided and the socio-economic situation of the community" (page 5). CESARs are not included in the list, suggesting that their fees will remain constant, in perpetuity. Another section of the regulation (page 10), states that "all MOH facilities, with the exception of health centers with community systems, will charge for services that are provided to the public the established tariff (which will be revised periodically by the competent entity of the MOH)." The ambiguous wording "competent entity of the MOH" is a source of confusion and uncertainty. In the judgment of many MOH officials and staff, it is the regional office that has the authority for changing prices, though others, citing that previous quotation, say it is the responsibility of the central level. The *Regulation* does not, however, specify what office or position in the MOH central office is supposed to pass judgment on proposed user fee changes. The uncertainty about who has the authority to revise fee levels has been an obstacle to their being changed.

The vagaries and ambiguities of the RFRM, are exacerbated by the high general level of ignorance about the RMRF. Only about one-quarter of the surveyed facilities reported that they knew about this official MOH user policy. Clearly, the MOH needs to better publicize and make its staff aware of and knowledgeable about official user fee policy. This is the first order of business in getting the UFSs to function more as intended.

The RFRM decentralizes the administration of the UFSs to the regional offices and indirectly, by not providing adequate guidance, grants them considerable discretion in structuring and operating the system. Predictably, the responses of the regional offices have been highly variable. The amount of staff, time, and other resources they devote to monitoring and supervising the UFSs in their regions varies highly. Some regions have several staff-persons who are dedicated to administering the system, while for other regional offices it is simply one of several activities for which a single individual is responsible. Some regional offices do a consistently poor job of administering the institutional systems. Most glaringly, one regional office providing comments on each of its facilities' institutional UFSs indicated that the system was what it described as "sporadic" in 71 percent of its facilities. What precisely does it mean to have a "sporadic" user fee system? Can the integrity of such a system be maintained?

Another regional office says the institutional systems have been replaced with community systems, and it (the regional office) therefore, has no oversight responsibilities. Yet, there are relatively few community health boards that supervise the community UFS in the region, and this is the singular criterion required by the RFRM to establish a CS. It would appear in this instance that the goals of "community participation" and "decentralization" are used as euphemisms to hide the fact that a regional office is abdicating its responsibilities.

There is also great diversity within the regions and across regions in the level of user fees, in the types of user fees and user fee systems, in exoneration policies, in the role of the regional office, in the degree of involvement and oversight by the regional offices. While institutional UFS have been ostensibly regulated by the RFRM for more than 10 years, the degree of adherence to the regulations varies substantially by region, type of facility, and, it appears, over time. While a user fee system should be flexible enough to allow the expression of local needs, Hondurans are ill-served by a system that is made of a patchwork of inconsistent, irrational, idiosyncratic decentralized systems. Local ability to shape the system must be tempered. It is necessary to balance local control with the need to have a predictable, understandable, and rational national system. It is the responsibility of the

MOH central office to establish the broad parameters of such a national system and to identify the ways in which it may be modified by local authorities to meet their specific needs.

Falling Levels of Real Income and the Low and Stagnant Cost Recovery Performance of Institutional User Fee Systems

Although this study focuses on outpatient-related fees, the sums discussed here include inpatient-related revenues as well. Annual total nominal institutional user fee revenues grew by an annual average of 23 percent from 1996 through 1999. Closer examination, however, reveals a less sanguine picture. Despite their rapid rate of growth in absolute, nominal terms, however, the relative significance of institutional user fee revenues has been and remains modest. Institutional UFS revenues as a proportion of total central government-funded MOH expenditures have remained small, hovering around 2 percent. Furthermore, when the impact of the substantial and persistent inflation that has plagued Honduras throughout much of the 1990s is taken into account (annually averaging 21 percent), the increase in user fees from 1996 to 1999 is only 10 percent, and varies substantially by type of facility. Between 1996 and 1999 only the national hospitals enjoyed an increase in real institutional user fee income. In real terms, the national hospitals' 1999 revenues were 142 percent their 1996 level, whereas the regional hospitals' was 42 percent less, the area hospitals' 45 percent less and the regions (here defined as only the CESAMOs and CESARs) was only three-quarters of what it had been three years earlier.

In summary, if the primary purpose of the Ministry's institutional user fee system is to generate income with which to defray costs, it has never been effective. Moreover, its effectiveness is faltering: it accounts for only a small and generally decreasing proportion of total costs. In area and regional hospitals and in CESAMOs and CESARs the institutional user fee systems are not holding their own; they are generating substantially less real income than they were four years ago. Only in the national hospitals has the performance trend been positive, but even there the systems cannot be regarded as being very effective as they garner only 3.8 percent of total central government-funded expenditures. Furthermore, with the majority of facilities never having changed their prices levels and holding the regional offices responsible for not allowing them to increase their fees, coupled with several of the regional offices apparently unaware of their having first-line responsibility for authorizing increases in fee levels, much of the MOH infrastructure is stuck in a dysfunctional and self-perpetuating situation, the end result of which is continually falling real levels of user fee revenues.

Institutional UFS Administrative Costs and Net Revenue Generation

The administrative costs of the institutional user fee system in 1999 are estimated at 23 million lempiras.[1] The MOH paid 81 percent of these costs, 18.7 million lempiras. If only the additional direct outlays that the MOH had to pay in order to operate the ISs are included, their total cost in 1999 was 14.3 million lempiras.

IUFSs' administrative costs are high relative to the income they generate. Costs are the equivalent of two-thirds (67 percent) of their revenues and vary dramatically by type of facility. The

[1] As described in greater detail in Chapter 5, this estimate of the administrative costs is not complete and under-estimates actual total costs. It was judged that the development of complete cost estimates would have been too time-consuming and would have made the survey too cumbersome and disruptive to the activities of facility staff. It is thought that the estimates presented here account for 75to 90 percent of the total, and probably more seriously under-estimates the costs of the higher level facilities.

magnitude of the cost burden varies from a low of 12 percent in national and regional hospitals, to 45 percent in area hospitals and reaches an astonishing 332 percent in CESAMOs and CESARs. In other words, for each lempira that is generated by the IS, in CESAMOs and CESARs, 3.32 lempiras are spent to administer the system. For the regions as a whole (i.e., just the area hospitals, CESAMOs and CESARs), administrative costs are 166 percent of their revenues. That is, for every 1.00 lempira in revenues the RO systems bring in, 1.66 lempiras are spent. Clearly, if the purpose of the IUFS is to contribute to cost recovery, the regions, and particularly and the CESAMOs and CESARs, would be better off it. Elimination of the institutional UFS in the regions would actually save the MOH money and/or enable its facilities to provide more care.

Another measure of the burden of the administrative costs of a user fee system is the net income they generate; i.e., the revenues left after subtracting costs. The net revenues of all of the MOH's institutional UFSs in 1999 were 11.1 million lempiras, and ranged from the national and regional hospitals' 19.3 million, to the area hospitals' 3.9 million and the CESAMOs' and CESARs' negative 12 million lempiras. The sum of the net revenues of the area hospitals, CESAMOs and CESARs was a negative 8.1 million lempiras. Again, elimination of the institutional UFS in the CESAMOs and CESARs in particular, and in the regions as a whole, would actually save the MOH money and/or enable its facilities to provide more care.

User Fees, Fungible Resources and Incentives: The Need for Central Office Leadership and RFRM Reform

It is imperative to note that facility directors and administrators point out that user fees are of disproportionately great importance to them (relative to other resources) because these revenues constitute most of the fungible resources that are readily available to them. For the most part, MOH resources are distributed in-kind, leaving relatively little room for the exercise of discretion and the timely purchase of the specific types and quantities of resources that a given facility might need. In contrast, user fees allow MOH staff to purchase exactly what they feel they need (within the rules and regulations relating to their handling), as opposed to, at best, being able to choose from what is available from the MOH, and having to accept the uncertainties of when and if it will actually be delivered. Moreover, they are readily available to meet unanticipated needs as they arise. These important differences result in many inefficiencies within the MOH system, as administrators are willing to use substantial amounts of existing MOH resources (e.g., personnel time) to obtain a much smaller value of liquid, fungible user fee revenues. While doing so may be economically irrational from a system perspective, from the individual administrator's/director's perspective it may be entirely rational.

This incongruity in the way in which user fees and other resources are valuated by officials working at different levels of the MOH makes it essential for the central office to demonstrate leadership in promoting and better ensuring the rational use of resources from the MOH's (overall) perspective. The current incentives for irrationally using MOH and GOH resources are also the product of an inadequately defined and inadequately understood administrative structure for both institutional and community UFSs at the local, regional and central levels of the MOH. The ambiguities concerning the ill-defined roles and responsibilities of the different MOH agents administering the systems have encouraged inaction, which, over time, has come to sap the system—particularly the institutional system—of its dynamism and eviscerated its potential role as a cost recovery mechanism. To the extent to which user fee systems have become more dynamic and more important as cost recovery tools, this has generally occurred where institutional systems have been supplanted by community systems. A substantial proportion of the community systems, however, are

of dubious legality due to the total absence (14 percent) or inadequate level of involvement (30 percent) of a community health board, the community system's legal *sine qua non*.

The community systems (legally constituted or otherwise) are not an unmitigated success either, however. There is no guarantee for the representation and participation of facility personnel on the community health boards, and only slightly more than half of facilities with a community UFS enjoy representation on their board. This is a potentially awkward situation that puts the facility at risk of being subjected to policies that reflect the interests of local leaders, rather than the needs of the health facilities, as has been the experience of other countries pursuing decentralization (c.f., Tang and Bloom, 2000). Health facilities should not be left out of the decision-making process in determining how user fee revenues will be used and made subordinate to persons who are not trained and do not work in health, and who are not knowledgeable about the health facilities' operations. This is a vulnerable position to which MOH staff and facilities should not be subjected. Such a situation is likely to dull the motivation of MOH personnel to collect user fees and thereby undermines a user fee system's performance. The impact of incentives in such systems is not unlike the situation that existed before the RFRM was passed, when the Ministry of Finance (MOF) insisted that UFs redound to the central treasury. With nothing to gain but the ire of their patients who now had to pay for care, Ministry personnel did not collect many revenues. The MOH central office now needs to exercise leadership to review and reform the structure, operations, and activities of user fee systems in order to get incentive structures right and, more generally, to reinvigorate these systems so that they are better able to realize their cost recovery potential. This work should start with a revision of the RFRM that more carefully defines the parameters governing the systems—especially the community UFSs—and that more generally reviews and reassesses the goals and the role of the MOH in Honduran society.

This study has provided a good understanding of the ambulatory care systems. While reform can start on these systems, it would ideal if an analysis of the hospitals' inpatient UFSs were conducted as soon as possible so that the reform could be comprehensive. During the course of this study, members of the MOH User Fee Study Committee reported that they had received a number of requests for specifically this type of study from hospital directors and administrators.

Recommendations for Reforming the RFRM to Improve the Performance of UFSs

The passage of the RFRM in 1990 was an important step in the development of the MOH. It has served the MOH well. It generated revenues for health facilities, while protecting the poor, and promoted decentralization. As this study has made clear, however, there are many shortcomings related to both the RFRM and to the implementation of MOH UFSs. After 10 years, these shortcomings are becoming increasingly restrictive and counterproductive to cost recovery efforts, and the RMRF needs to be revised. The following recommendations are made for reforming the RFRM:

1. To re-establish fee levels at their real 1990 levels, user fee levels should be increased five-fold.
2. Introduce fees that cascade by facility levels. For instance, set outpatient consultation fees for: CESARs at 5 lempiras, CESAMOs at 10 lempiras, and hospitals at 15 lempiras. Consider cascading fees within hospital types as well. For example, charge 25 lempiras for an outpatient visit at a national hospital, 20 lempiras at a regional hospital, and 15 lempiras at an area hospital.
3. Review the contentious exemptions policy of the RFRM. Clarify specifically what categories of persons (including the RFRM's ambiguous "active, community personnel") are to be

exempted from payment. Explicitly state whether MOH employees and/or their families are to be exonerated. Establish national level guidelines for identifying indigents.

4. Revise RMRF purchasing restrictions, at minimum, to re-establish their real 1990 levels. (See Table ES-1.)
5. The MOH should modify the RMRF regulations so as to start moving the Ministry toward a performance-based system. The regional offices' share of user fee revenues (10 percent of hospitals, 25 percent of health centers) should be used to establish a performance-based incentive scheme. Facilities that fulfill their performance goals should be awarded a "bonus" consisting of the revenues they would have otherwise had to have shared with the regional office. Those that do not fulfill their goals, would be subject to losing the shared revenue and the regional office would use it as it sees fit.
6. The San Felipe Regional Office's accounting and supervisory system for user fees is a model worthy of emulation. It should be used to establish uniform administrative standards for institutional user fee systems.
7. There is a need to clarify and raise awareness throughout the MOH and Honduran society of the RFRM, its rationale, its goals and the processes and procedures it establishes. The MOH needs to print and distribute to each facility a copy of the RFRM, and hold a series of regional office-sponsored meetings to discuss the regulations.
8. A series of public meetings should also be held and a publicity campaign undertaken for the same purpose. It is important to dispel doubts and address concerns about UFSs and new fee levels.
9. There is a need to more precisely and comprehensively define what is a community user fee system. The MOH should develop more specific regulations governing the formation, composition, and terms of office of health boards, as well as suggest operating procedures and protocols.
10. Health boards that manage UF revenues should be required to have a voting representative of the local health facility director's choice on the board.
11. To promote community participation, accountability, and transparency, consideration should be given to requiring the health board to make periodic public reports on user fee revenues and expenditures (e.g., at the *cabildos abiertos*), and to make supporting documents readily available to the public.
12. The MOH should provide guidance (suggestions) and/or regulations (legally enforced requirements) about the types of structures, operating procedures, and domains for local entities interacting with a local MOH facility. The goal should be to promote community participation, while obviating conflict and protecting the integrity and operations of the local health care facility.
13. To draft these proposed changes—guidance, rules and/or regulations—a working group should be convoked. (A suggested list of MOH and other organizational representatives is presented in Chapter 8.)
14. Determine if hospitals, or some subset of the hospitals, should have a different type of user fee system, or if they should be allowed to operate their systems independently. In either case, a uniform set of national guidelines should be developed that all are required to follow.
15. The Central Bank of Honduras' Department of Economic Studies, Division of Economic Aggregates, Economic Indicators Section should be tasked with using either the medical care price index component of the Consumer Price Index, or preferably, constructing a MOH-

specific price index, that will be used to annually readjust MOH user fee levels to maintain them at the same constant, real value.[2]

16. Most of the 10 percent of all UFSs have mixed systems, and administer these systems independently. This duplication wastes resources and reduces potential net income generation. These systems should be eliminated, by eliminating their institutional component and making them entirely community-based systems.

The Case for a More Comprehensive Reassessment and Restructuring of the Current User Fee Policy Framework

The recommendations in the preceding section are predicated on the assumption that while current official policy will be modified, the general framework that the RFRM established 10 years ago will be retained. But should it? It is recommended that due consideration be given to fundamentally reformulating official MOH user fee policy, so that the Ministry's user fee policy be made more effective, more participatory, more compatible with, and more supportive of the GOH's decentralization efforts.

The GOH's modernization plan calls for transferring much of what the central government does down to the municipality. To be in-step with this plan, and to anticipate changes that otherwise will likely eventually be foisted on the MOH in order to make it consistent with the rest of the government, the Ministry would have to transfer responsibility and authority to municipal governments. This study has found that there is significantly greater satisfaction with CSs compared to ISs among both the health facility and community health board respondents. The basic approach of the community user fee systems is one which is popular, consistent with, and supportive of the GOH's public sector modernization program. It could be adopted and adapted to devolve oversight of the UFSs to the municipal governments, rather than to, or at least as an alternative to, the community health boards.

It would be advisable to recognize that there are problems with these systems which were identified in the survey, and which should be addressed before adopting this approach as a means for devolving oversight of the UFSs to the municipal governments. Most of the problems have a common root, and stem from the nature of this type of decentralization, viz., devolution. In this case, devolution has meant that non-health people have been given authority over the health sector. Because health personnel are not being given representation to communicate the health facility's needs and are not being able to participate in the decision-making process to determine what is to be done with the user fee revenues generated by the health facility, many health staff working in community systems feel vulnerable, "robbed" of their facility's income and powerless, and with reduced motivation for collecting fees. While the proposed reforms are intended to ameliorate this situation, the community system will continue to be headed by the community health board, which is likely to eventually prove problematic (as explained below). At the other extreme are the community systems that independently manage their own funds either because the community health board no longer functions or is not interested in managing these monies. Both of these situations reflect what

[2] The Central Bank should be tasked with this responsibility, rather than the MOH, because this will better ensure its technical precision and will insulate the MOH from the political fall out of the annual increases. Each January the Central Bank should announce the next user fee levels and print the changes in the official government publication. Changes in fee levels should take into practical considerations, as well, so as not to increase the transactions cost of collecting the fees. For instance, if the inflation adjustment requires an increase to 3.32 lempiras, for example, the fee level should be increased to 3.25 or 3.30 so that making change does not become an unnecessarily time-consuming task.

this study and others have found (c.f., Fiedler and Godoy, 1999 and Corrales, et al., 1998): that maintaining adequate interest, vigor, and transparency in activities in which there is community participation with authority resting in a largely unstructured, *ad hoc* entity—such as a community health board—has been and, in all likelihood will always be, problematic. While the proposed reforms seek to obviate these potential shortcomings, the sustainability of quantitatively and qualitatively meaningful community participation could be better ensured if a more permanent, more institutionalized system were developed. Properly restructured, devolution to the municipal level and, more specifically, to a municipal health committee, offers an attractive alternative with greater, more enduring promise.

It should be acknowledged, however, that devolving oversight of the user fee systems to the municipal level probably entails greater risks for the MOH and for health facilities than simple deconcentration. Again, this is due to the distinct nature of devolution vis-à-vis deconcentration. The municipal governments, to date, are not knowledgeable about the health sector or the functioning of health facilities or their user fee systems, and, in fact, until very recently have not even been much involved in the health sector. Devolution of oversight of the user fee systems to the municipal health committee, therefore, runs the same risks as devolution to the community health board; viz., that non-health people who are put in a position of authority over the health sector may compromise the health sector for other goals these persons might have.

In response to this scenario, two observations are in order. First, the knowledge of municipal authorities, in general, about the health sector is increasing rapidly, and is likely to continue to increase for two reasons:

1. As has been demonstrated in this study, at the local level Hondurans regard health as an important priority, and, as politicians, municipal authorities are likely to be aware of and responsive to this keen interest.

2. Municipal governments have been financially empowered by the new Law of Municipalities-established revenue sharing scheme, and they are putting their money where their priorities are, i.e., into their local health facility.

The second observation is that the terms by which the supervision of the user fee systems are devolved to the municipal health committee are subject to negotiation. The MOH should be prepared to play a prominent role in structuring this relationship so as to better ensure that health and the interests of public health officials are well served. The Ministry can achieve this goal by adopting many of the same reforms recommended earlier for the community user fee systems and applying them to the proposed municipal health committee systems as well. These reforms seek to strengthen the health facility's position within the devolved system, thereby making this a more attractive option for MOH facility staff, while providing a more structured set of regulations that make the system more participatory and more transparent, thereby enhancing its appeal to the community.

It is imperative that these reforms also be structured in such a manner as to ensure that the Ministry of Health retains the ability to effectively implement a national health policy. In other words, there is a need to strike a balance between devolving authority and responsibility to the municipality, while retaining adequate authority at the central level so as to protect the integrity of the health sector and retain the Ministry's ability to establish national health priorities and lead the health sector in pursuing those priorities.

Although municipal governments are already actively involved in supporting MOH facilities, the majority of facility representatives interviewed in this study expressed reservations and generally did

not support the idea of having the municipal government take the place of the regional office as the supervisor of local user fee systems. It must be recognized, however, that their expressed preferences are conditioned by their experiences, which in many cases are shaped by the ill-defined community UFSs and their community health boards, and/or by the interactions between the municipal government and the facility, which to date have been unstructured.

Another way in which the facility-municipal government relationship could be structured so as to obviate some of the specific concerns raised by the facility personnel would be to prohibit the expenditures of a facility's user fee revenues for anything other than the facility's needs. This prohibition could also be complemented with the stipulation that only the municipal health committee has the authority to determine how those funds are spent. The role of the municipal government would be limited to providing oversight of the revenues; ensuring the integrity of the monies.

Furthermore, the GOH could make it optional for communities (through their *cabildos abiertos*) to enter into this type of relationship, much like the RFRM did for the development of community health boards to govern community UFSs. Making the relationship between a municipal government and a health facility voluntary, together with the recommended reforms to better ensure the representation of, or independence of, the health facility would further heighten awareness that the relationship is more of a partnership, while promoting transparency in the management of the monies. Consideration might also be given to establishing a phasing-in period during which this type of relationship could be entered into voluntarily, with a schedule, or perhaps only the hope that later it might become universal and mandatory. The phase-in could include annual assessments of how well the system is working, with the introduction of subsequent modifications to address identified shortcomings.

The proposed approach serves several ends simultaneously, some of which have already been mentioned but merit reiteration at this juncture. This approach would constitute the first step in the long talked about, but long delayed beginning of the decentralization of the Ministry of Health. Second, it overcomes the impasse regarding to what level of government the MOH is to be decentralized. Third, it is consistent with the GOH's decentralization plans that are focused on the municipality. Fourth, it constitutes what may be regarded as the first step in eventually devolving the Honduras public health care delivery system (at least the health centers) to municipal governments. This is consistent with the Ministry's ultimate, long term goal of getting out of the business of being a direct provider of health care, while increasingly focusing its activities exclusively on financing, regulation and being the rector of the health sector.

Conclusion

The effectiveness of the Ministry of Health's user fee systems has been slowly crumbling under the weight of the increasingly restrictive and outmoded RFRM. There is an urgent and growing need to reform the RFRM so as to enable the restructuring and reinvigoration of these systems. Fee levels need to be increased, and the systems need to be made more formal, with more explicitly established operating goals, rules and procedures so that they are more effective in recovering costs and encouraging community participation in a manner that obviates conflict, promotes transparency, and yet protects the resources, operations and integrity of the local health facility's operations and the operations of the entire MOH. This study has made a series of what should be regarded as minimum recommendations for revising the RFRM. It has called for the formation of a working group to oversee this process and to consider a more ambitious agenda, which aims to integrate the Ministry of Health more fully into the Government of Honduras' general decentralization initiative by devolving oversight of the UFS to municipal governments. The devolution proposal is highly flexible and serves the present and future needs of both the Ministry of Health and Honduran society.

1. Introduction

1.1 Legal Framework and Historical Development

The Ministry of Health (MOH) of Honduras was established in 1954, and user fees began being charged in some MOH facilities shortly thereafter. Initially fees were primarily a hospital phenomenon. They were especially common in the national hospitals, but they slowly spread to include virtually all of the hospitals and many of the health centers with physicians (referred to as CESAMOs (Centros de Salud con Médicos y Otros). For three decades the system evolved without a national policy or official guidelines. It came to consist of a patchwork of idiosyncratic, individual facility-determined policies. The first major national MOH user fee policy was issued in 1984. It implicitly recognized the *de facto* existence of user fee systems and called for MOH hospitals to increase their user fee revenues to 20 percent of income. Since the Ministry of Finance (MOF) required that all MOH user fee revenues redound to the national treasury, however, there existed little incentive for MOH facilities to collect fees. Consequently, the value of institutional user fee revenues remained low, and has never exceeded two or three percent of total MOH public treasury-funded expenditures.

In 1988, a United States Agency for International Development-Government of Honduras (USAID-GOH) Agreement stipulated the end of this MOF requirement.[3] The Agreement was subsequently passed into a law that stated that MOH facilities collecting user fees would thereafter be able to retain control of these monies. This fundamental reform touched off a major overhauling of the MOH facilities' user fee systems, culminating in the development of a national system. On August 1, 1990, a presidential agreement (Acuerdo Presidencial Número 1664) authorized the "retention and management" of user fees at the same facility where they were collected. This decree was followed in September 1990 by the publication of the "Regulation and Manual for Recovered Funds" ("Reglamento y Manual de Fondos Recuperados," or RMRF), which came to be the central government's defining document establishing a national user fee policy.

Since its issuance, there have been two modifications of the Agreement. On August 7, 1990 Internal Resolution Number 0001-91-A was issued, and was followed on January 10, 1991 by Resolution Number 0002-91-A. Both of these modifications involved the introduction of (additional) restrictions on the potential use of the user fee revenues. Most importantly, they prohibit using the funds to hire more personnel. In the more than nine years since the resolutions were issued, there has been no official change in, or official pronouncements about, user fee policy or user fee guidelines.

The 51-page RMRF provides a detailed framework for the structure and operating procedures of an official, MOH institution-based user fee system, which includes rules, regulations reporting requirements (including prototypes of reporting forms), and identifies and assigns specific management, accounting and supervisory responsibilities to specific MOH positions or designees. The RMRF also allows for the development of another user fee system, one that is operated and controlled by the "community." The former system, the official MOH one, is referred to as the

[3] This was Donation Agreement 522-0216, the content of which became law in Honduras when it was approved by Legislative Decree Number 93-68.

"institutional" system (IS). The latter is referred to as the "community system" (CS). While recognizing the legitimacy of the CSs, the RMRF does not establish any requirements or even provide guidance about a CS's structure or operating procedures. While it does call for these systems to be operated by a "community health board," it does not stipulate what such a board is, how it should be formed or how it should function. The RMRF does, however, allow for considerably greater independence of these ill-defined institutions. They are not required to adhere to the RMRF, and are not required to report to, and are not monitored by, any MOH or other Central Government entity. While it is recognized that these systems have been growing in number in recent years, there is only anecdotal information about the number, structure, operations and financial significance of these independent, decentralized systems.

1.2 Purpose of the Study

There has never been an assessment of the implementation of the RMRF or its modifications. Nor does there exist a source of routinely available information about the degree of concurrence between the law and the existing systems. The only regular source of information about the user fee system is a reporting system for institutional user fee revenues and expenditures. This system consists of the individual national and regional hospitals, together with the Regional Offices submitting monthly reports of user fee income and expenditures to the MOH's Planning and Management Evaluation Unit and its Department of Administration, as well as to the Ministry of Economy's General Accountant's Office. According to this information, institutional user fee revenues in 1999 totaled 34.1 million lempiras and had been growing at the brisk pace of 25 percent annually since 1997.

The growth in user fee revenues was likely one of the factors sparking interest in this study, but there were other, more important factors. First, there was growing general awareness of several shortcomings of the RMRF that were becoming increasingly important impediments to the use of this income. A second contributing factor was the growing number of anecdotes about various dysfunctional aspects of the loosely shepherded system (for details, see the author's PHR Trip Report: Honduras, September 20-October 6, 1999 for an itemization of 16 specific problems relating to RMRF regulations or how it has been implemented). A third factor has been the growing desire to know more about the financial importance, role and impact of the proliferating community user fee systems. Finally, there was the general recognition that—nearly a decade since the RMRF was established—it simply was time to review user fee levels, policies and practices in order to understand what they are, how the system functions, and how, given the goals and objectives of the Honduran MOH, their effectiveness, efficiency and equity might be improved.

These considerations, together with the potentially important role the system could play in fostering decentralization, as well as other MOH-identified reform objectives, served to make a systematic analysis of user fees an MOH priority. In July 1999, the Minister of Health, Plutárco Castellanos, officially requested USAID/Honduras' assistance in undertaking a study of the Ministry of Health's user fee system.

1.3 The Scope of the Study is Limited to Ambulatory Care

This study is limited to an analysis of the ambulatory care user fees. Inpatient care is not analyzed. The decision not to include inpatient care was made because it was thought that the level of fees charged for inpatient care should reflect the cost of care, and there is no information on the cost of inpatient care in MOH facilities. Such a cost study should be conducted. Thereafter, an analysis of

inpatient charges should be undertaken. Many of the findings of this study will serve to inform that effort.

2. Study Design and Methodology

2.1 Study Design

This study was conducted by a team led by Jack Fiedler and Lic. Javier Suazo, consultants to the USAID Partnerships for Health Reform (PHR) Project, and Lic. María Sandoval, Director of Finance of the Planning and Management Evaluation Unit (UPEG) of the Ministry of Health. They were assisted by the PHR long term advisor to Honduras, Dr. Francisco Vallejo, and the MOH User Fee Study Committee. The committee, headed by Lic. Sandoval, consisted of Lic. Vilma Mendoza, Dr. Rosa María Flores, Dr. Jorge Cano and Dra. Guadalupe Romero.

The development of the design for this study was a two-step process. The first step consisted of a series of interviews with persons working in the MOH central office and a convenience sample of regional offices and facilities, as well as employees of the Ministry of Economy's General Accountant's Office and staff of the Association of Municipalities of Honduras (AMHON). Pertinent official and legal documents were identified and reviewed. The purpose of this phase of the study was to become knowledgeable about the legal framework, as well as the general characteristics, operating procedures, and any commonly construed problems of the user fee system. The intent was to design the study so as to ensure that relevant empirical data would be assembled to enable thoroughly understanding the current user fee systems, while also being sure that alternative potential reforms or modifications of the systems could be identified and investigated. This attempt to envision and explore alternative potential future realities was guided by stated goals and objectives of the GOH and the MOH, most importantly the promotion of decentralization and community participation. Hence, the study design was shaped to a significant extent by the desire to have information about the community systems and community participation.

This phase of the study culminated with the development and application of the user fee inventory questionnaire. This questionnaire was used in interviews with regional office personnel and health area chiefs to develop an inventory of the type of user fee system (institutional, community or combined) in each individual health facility in the country. This was the first inventory of user fee systems ever assembled in Honduras. The questionnaire was also used to collect information about characteristics of each facility that were hypothesized to affect the amount of user fee revenues generated by the facility. This information was essential to the development of a sampling frame that

could be used to develop a representative sample of facilities that would be surveyed to develop reliable, national level estimates of revenues in the community user fee systems.[4]

Phase two of the study design consisted of analysis of the user fee system inventory, the development and application of a sampling methodology, identifying the sample of facilities to be surveyed, the design of questionnaires, the development of indicators of performance and a draft outline of the final report.

2.2 Questionnaire Development, Testing and Application

As noted in the first chapter, the only systematic source of information about user fee systems available in the MOH central office is the monthly revenue and expenditures reporting system. The study, therefore, required a substantial primary data collection activity. Fiedler and Suazo developed the questionnaires with considerable input from the MOH User Fee Study Committee. Specific questionnaires were developed for (1) MOH facilities, (2) the MOH regional offices, and to gather information about community participation and local level views of the systems, there were questionnaires for (3) community health boards, and (4) a representative of the municipal government (the mayor's office, *alcalde*).

Four interviewers were hired for the fieldwork. They were oriented to the purpose of the study and trained in the application of each individual question by Fiedler and Suazo, with the participation of the MOH User Fee Study Committee. The questionnaires were field-tested by teams consisting of an interviewer and a member of the MOH User Fee Study Committee. Members of the Committee and Lic. Suazo conducted the interviews in the hospitals and regional offices, while the four hired interviewers did all of the interviews in the CESARs and CESAMOs. Annex B contains copies of the questionnaires.

The sampling methodology is explained in detail in Annex A. The methodology was designed to provide a sample for each region that would ensure that a representative combination of facilities, types and productive levels of user fee systems would be surveyed. A sample of 188 specific facilities was identified. The interviewers worked under the direction of Lic. Suazo and conducted the survey between January 2000 and April 2000. While the number of facilities actually sampled (186) was nearly identical to the original design, the composition of facilities surveyed varied (for a variety of reasons discussed in Annex A). The surveyed facilities were 86 CESARs, 71 CESAMOs and 28 hospitals.

4 The study design also called for an analysis of the 1998 National Household Income and Expenditures Survey. This survey, conducted by the General Directorate of Statistics and Census and the Central Bank of Honduras, contained a health component consisting of more than 100 questions about health care behavior. The critical component of this analysis was to be an estimation of the sensitivity of Hondurans to changes in the price of health care; i.e., an estimation of the price elasticity of demand. The elasticity was to be used in conjunction with information from the user fees survey to quantitatively investigate the impact of changes in user fee prices on (1) access to care and (2) the level of utilization of MOH facilities. It was intended that recommendations about changes in MOH user fee levels would be based on this analysis. The entire database was never made available for analysis, despite repeated efforts of the PHR long term resident advisor, precluding the development of elasticity estimates. A portion of the ENIGH data, however, are presented and discussed in this report.

The sample of community health boards and mayors' offices surveyed was derivative of the facility survey. The representatives of the facilities that were interviewed were asked if there was a community health board or a municipal health committee. Where there was, they were interviewed. Representatives of 82 health committees and 53 mayors' offices were interviewed.

Finally, all nine MOH regional offices were surveyed. There were a total of 330 interviews.

The interview data were entered into electronic files after the fieldwork was completed. The data analysis was done using the Statistical package for the Social Sciences (SPSS) and Microsoft Excel.

2.3 Archival Data

A variety of archival data were collected and analyzed. The UPEG's data on institutional user fee revenues and expenditures for the past four years were collected and analyzed. In addition, the MOH's Statistics Unit provided copies of the 1999 RUPS file, the master AT2 data files for 1995-1999 and the weekly infectious disease surveillance system data files for 1995-1999. The RUPS file is the Ministry's definitive official listing of the names, locations and classifications of each of its more than 1,100 facilities. These data were used to corroborate data from the UPEG survey and to develop the sampling frame for the user fee systems survey. The AT2 files and the infectious disease database both contain official consultation data by facility and type of consultation provided. These data were also used in developing the sample of facilities to survey and to obviate the need to collect these data at the individual facilities during the survey. (As discussed in detail later in this report, total consultation data were used to develop indicators of user fee performance. Also to be discussed further in a subsequent chapter, these data were used in combination with results of the user fee system survey to investigate the degree of adherence to the MOH policy that certain specific types of services be provided free-of-charge, and the financial implications of this policy and practices.)

3. An Overview of Honduran User Fee Systems

The purpose of this chapter is to provide the reader with a general orientation and understanding of user fee systems in Honduras before turning to the more detailed survey results in subsequent chapters. The chapter consists of two sections. It begins with a discussion of *The Regulation and Manual for Recovered Funds* and how it governs the nature of user fee systems, thereby conditioning their equity, efficiency and effectiveness. The second section of the chapter presents the findings from the first inventory of user fee systems ever conducted in Honduras, and discusses the numbers, types and locations of user fee systems.

3.1 Critical Elements of the RMRF Shaping the Institutional User Fee Administrative Systems

The Regulation and Manual for Recovered Funds, which establishes the legal framework governing the structure and operations of the user fee systems in the Ministry of Health's facilities, is too detailed to review in its entirety in this report. It is, however, essential to discuss portions of the *Regulation* in order to understand the functioning of the user fee systems and the legal parameters effecting their operations. The discussion turns to a generalized description of the MOH's institutional user fee system, focusing on the ways in which the RMRF shapes the typical facility's system, particularly those that the facilities regard as most onerous and in need of modification.

3.1.1 The Role of the Regional Offices

The RMRF establishes the regional offices as the hub of the institutional user fee system. It charges them with overseeing the administration of all facilities in their region, including all hospitals, and grants them the authority to make all major decisions that shape the nature and operations of the user fee system in their domain, with the important exception of setting fee levels. The authority for setting institutional user fee levels is assigned to the Central Level (page 5).

3.1.2 Administrative Requirements

The RMRF calls for the use of official GOH receipts (*talonarios*) to document every user fee transaction. These receipts are authorized and printed by the General Accounting Office of the Ministry of Finance payment system and officially monitored (*fiscalizado*) by the Controller General Office of the Ministry of Finance. The receipts are pre-enumerated and printed in booklets of 50 one-page, two-part receipts. One portion of each page is the patient's paid receipt which is perforated to enable easily tearing it out of the booklet, while the other portion, a stub, remains in the booklet. Both sides of each page (the receipt and the stub) are pre-enumerated. The RMRF assigns the regional offices the responsibility of purchasing these receipts using their general, Central Government budget allocations. A booklet of receipts costs 40 lempiras. Thus the cost of a receipt for a single patient transaction is 80 centavos (0.80 lempiras).

The RFRM requires all facilities to deposit all institutional user fee revenues in a State-owned bank. Facilities may establish a rotating fund, but the RMFR establishes that the maximum amount of money a rotating fund may hold at any time is 2,000 lempiras. Monies must be remitted monthly to the regional office. These monies remain the collecting facility's earmarked resources, but they are controlled by the regional office. In the event that facility chooses to spend more than 2,000 lempiras of their UFRs in any given month, the facility must spend its rotating fund then make a trip to the regional office to obtain the reimbursement for the outlay in order to replenish the fund. Facilities with sizeable revenues and expenditures may need to make several trips to the regional office each month in order to comply with the 2,000 lempira restriction on rotating funds.

The RFRM prohibits spending institutional user fee revenues on personnel. Purchases are permitted on only three general expenditure categories: non-personnel services, materials and supplies and machinery and equipment. Another expenditure restriction is that facilities are required to obtain at least three written quotes when purchasing an item valued at more than 100 lempiras.

Before the tenth day of each month, the regional offices are charged with reviewing the revenues and expenditures of each institutional system in the region, and submitting a report documenting the total revenues and total expenditures of all institutional user fee systems in the region. The RMRF stipulates that a copy of this report must be sent to the MOH's Planning Department, Division of Hospitals and the Administrative Directorate (Division of Accounting), and the Ministry's Department of Internal Auditing. In addition, income and expenditures reports must be sent to the Ministry of Finance's Controller General and the General Accounting Offices While the regional offices maintain individual facility-specific accounts, the reports they submit contains only aggregated data for the entire region. Each hospital is also required to submit this report to the same authorities.

The RMRF states that the regional offices are entitled to 10 percent of the total institutional user fee revenues garnered by each hospital and 25 percent of those of the CESAMOs and CESARs. The Regulation directs the regional offices to exact their shares at the end of each month. These monies may be used at the discretion of the regional office for its own operations or to support the operations of one or more facilities in its regional network.

The chief motivation for most of the regulations discussed up to this point was to make the system transparent. The RMRF also attempts to promote efficiency and equity. It promotes efficiency by mandating that certain services be provided free-of-charge. These services are generally ones that are either preventive in nature (and generally regarded cost-effective) or that have high positive externalities (and, if charged for, are likely to be provided in less than socially optimum quantities). They are:

- immunizations,
- prenatal care,
- family planning,
- growth and development (well-child) visits,
- tuberculosis treatment, and
- treatment of sexually transmitted diseases.

The RMRF promotes equity by stating that persons identified as poor may be partially or completely exempted from payment. The Regulation implicitly sanctions the use of local criteria (by the social worker or his/her representative) in making the determination of who is medically indigent . The RMRF also states that facilities "will revise and/or periodically adjust" their fees (with pre-approval of the MOH Central Office) taking into account the "socio-economic situation of the community."

The RMRF specifically identifies the elements of the accounting and information system that are to be used to track the revenues, including the receipts (discussed earlier), a ledger/balance sheet, bank deposit forms, daily and monthly summary report forms and a monthly summary report of accumulated user fee revenues form. It also identifies the specific functions and responsibilities of specific staff-persons in each of the different types of facilities.

Finally, the RMRF grants CESARs and CESAMOs the right to establish a community user fee system. The prerequisites for having such a system is that there be a community health committee and that committee must manage the system. The Regulation states that the authority for establishing a CS rests with the regional office, working through the Health Area Offices. However, it provides no explicit requirements and offers no advice about what the structure, composition or activities of a community health committee should or must be, in order to be recognized. These definitions and judgments are left to the discretion of each regional office. The community health committee is given the sole authority to establish their fee levels (page 10).

Clearly, the intent of the RMRF in providing enabling legislation for the development of CSs, with their less onerous administrative and reporting requirements and their unrestricted use of funds was to encourage community participation.

3.2 The Inventory of User Fee Systems in Honduras

3.2.1 The Prevalence of the Different Types of UFSs

Table 1 presents the number, composition and regional location of the MOH's 1,157 facilities. The inventory gathered information on the user fee system status of 1,128 or 97 percent of all Ministry facilities. The only facility for which information was obtained about Region 8, Puerto Lempira's 30 facilities was the area hospital. While the data for that facility is included throughout the following discussion, it should not be regarded as representative of other facilities in the region. This shortcoming should be borne in mind in interpreting the Region 8 data, throughout the remainder of this report.

There are three types of UFSs in MOH facilities:

1. an institutional system (only),
2. a community system (only), and
3. a so-called "mixed" systems; i.e., systems which are combinations of both an IS and a CS.[5]

[5] An effort was made to distinguish two types of "mixed" systems. Those in which the two systems are maintained independently and unintegrated, and those which have been integrated into a single system. This distinction, however, was difficult to maintain, and resulting in inconsistencies in identifying and classifying some systems. The attempt to make the distinction was therefore abandoned.

Table 1: The Infrastructure of the Ministry of Health, 1999

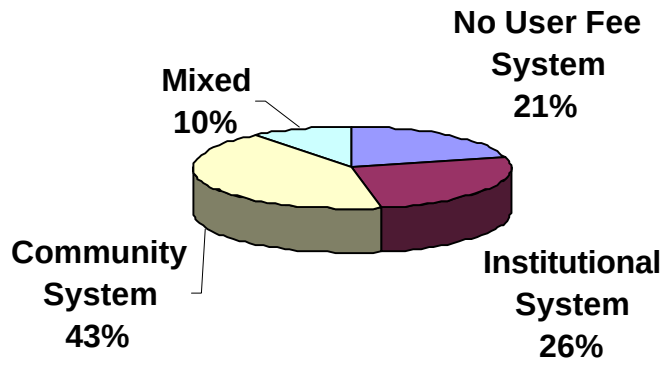
Levels of Care of the Ministry of Health

Region	National Hospital	Regional Hospital	Area Hospital	CESAMO	CESAR	Maternal-Infant Clinic	CLIPER	Dental Student Centers	Total Number of Facilities
0 Metropolitana	6			17	17		3	2	45
1 San Felipe			1	42	97	1		1	142
2 Comayagua		1	2	22	129	3		1	158
3 San Pedro Sula	1	1	4	58	112			2	178
4 Choluteca		1	1	27	152	5		1	187
5 Copan		1	2	32	128	2		1	166
6 La Ceiba		1	5	27	87			1	121
7 Juticalpa		1		20	107	1		1	130
8 Puerto Lempira			1	9	19			1	30
Total:	**7**	**6**	**16**	**254**	**848**	**12**	**3**	**11**	**1157**
Percentage:	0.6%	0.5%	1.4%	22.0%	73.3%	1.0%	0.3%	1.0%	100.0%

Source: UPEG/MOH survey

According to the regional office and health area officials interviewed, 79 percent of MOH facilities have a user fee system. As Figure 1 shows, the CS (alone) is by far the most common type of UFS, and exists in 43 percent of MOH facilities. The IS system (alone) is the next most common type. It is found in one-quarter (26 percent) of MOH facilities. The remainder of those with a UFS, 10 percent, have a mixed system.

Figure 1: The Composition of MOH Facilities' User Fee Systems, 1999



3.2.2 A Caveat about the Imprecise Definitions of the Three Types of UFSs

While respondents identified 233 MOH facilities that do not have any type of UFS, these were not always definitive characterizations. Respondents noted that in 26 of these facilities, one of the staff gathers fees or contributions or that contributions are used to pay the janitor or some other staff person. Respondents also noted that 22 facilities that had institutional systems used them to pay personnel, which is expressly forbidden by the RMRF. These observations suggest that the RMRF definitions of the terms "community" and "institutional" user fee systems, and more specifically, what distinguishes the different types of user fee systems, is not universally well understood.

The respondents' comments together with insights from field trips suggests that there are several factors contributing to (a) the blurring of the distinction between community and institutional, and, more basically, about (b) what constitutes a user fee system. First, some of the systems are based on voluntary contributions and function only occasionally. Second, while fees are being collected and spent by the staff of a facility, in some instances the fee system was originally established as a community system, but the health committee is not longer functioning. Third, the respondents may be aware that the RMRF prohibits using institutional fees to pay personnel, and may simply presume that if a facility is generating fees and paying personnel that it must have a community system (perhaps in addition to an institutional system).

Given the importance of the distinction between community and institutional user fees in the RMRF, the lack of clear understanding about the criteria that differentiate these two types of systems manifests a fundamental shortcoming of the Ministry of Health's user fee policy. It should be acknowledged that the root of the shortcoming is the RMRF itself. It never clearly defines what a community system is or whether it is an alternative to an institutional system. Nor does it explain what happens if the circumstances in a community change. What happens, for instance, if a health committee becomes moribund? Should the community system revert to an institutional one? What

happens if a health committee allows the facility staff to manage their user fee revenues completely independently? Is that permissible? The RMRF simply leaves too many questions unanswered. It does not provide an adequate framework for a national user fee policy. There is a need to clarify user fee policy, to establish a more detailed, clearly articulated national user fee policy.

Recognizing that there is some vagueness about what constitutes a community user fee system and what constitutes an institutional one, does not necessarily mean that these are no longer useful concepts. The purpose of this study is to assess the user fee systems of Honduras and to offer methods for modifying them in order to improve their performances in a manner consistent with MOH goals and objectives. Thus there is a need to be able to discuss how different characteristics of user fee systems affect their performance and the impact. Obviously we cannot look at each of the roughly 900 systems individually. We need some tools for generalizing and simplifying the analysis. One such tool that will be used in making this assessment will be to juxtapose community and institutional systems. It will be necessary to remain cognizant of the shortcomings of these terms throughout the study.

3.2.3 The Prevalence of UFS by Type of MOH Facility

Table 2 shows the composition of user fee systems by type of facility. All of the hospitals 28 hospitals have user fee systems. Disregarding the numerically insignificant Maternal-Infant Clinics, CLIPERs and Dental Student Clinics (which together comprise only 2 percent of MOH facilities), CESAMOs are the next most likely type of MOH facility to have a user fee system.[6] Ninety percent of them are reported to have a UFS, compared to 76 percent of the CESARs.

The conventional wisdom (expressed by many Central Government officials in the design phase of this study) is that CESARs are not allowed to have a user fee system, especially an institutional one. The high prevalence of user fee systems found within CESARs was therefore unexpected. The bulk of the systems in CESARs, 75 percent, are community systems; only 18 percent are institutional systems. Many of the CESARs that have ISs are reportedly facilities that were formerly CESAMOs when they established their IS, and that later evolved into a CESAR, when they were no longer staffed by a physician (usually because they lost their National Service physician). Nearly all (96 percent) of the 485 (43 percent of) MOH facilities that have only a CS, are CESARs. Still, only 56 percent of all CESARs have only a CS. These relative proportions are roughly reversed in CESAMOs; 57 percent have an IS, while only 7 percent are reported to have a community system.

All of the systems in hospitals are institutional, although the nomenclature becomes a less precise in the case of hospitals. The relative imprecision is due to the fact that most of the hospital's operate their systems largely independently, which tends to blur the distinction between community and institutional systems.

It is hypothesized that because the incentive structures and administrative and supervisory systems of the CSs and ISs vary considerably, they probably generate very different levels of revenues.

As already noted, there is no systematic information on the number or operations of the community user fee systems. The inventory finding that there are 70 percent more CSs than ISs

Table 2
The User Fee System Inventory:
Types of User Fee Systems by Type of Facility

Type of Facility	Have No UFS	Institutional System	Community System	Both IS & CS	All Facilities	Facilities with At Least One UFS
National Hospitals*	0	7	0	0	7	7
	0%	100%	0%	0%	100%	0.8%
Regional Hospitals	0	6	0	0	6	6
	0%	100%	0%	0%	100%	0.7%
Area Hospitals	0	16	0	0	16	16
	0%	100%	0%	0%	100%	1.8%
CESAMOs	24	139	15	67	245	221
	10%	57%	6%	27%	100%	24.7%
CESARs	202	114	468	45	829	627
	24%	14%	56%	5%	100%	70.1%
Maternal-Infant Clinic	0	10	0	2	12	12
	0%	83%	0%	17%	100%	1.3%
CLIPER	1	2	0	0	3	2
	33%	67%	0%	0%	100%	0.2%
Dental Student Clinic	6	1	2	1	10	4
	60%	10%	20%	10%	100%	0.4%
Total - All Facilities:	**233**	**295**	**485**	**115**	**1128**	**895**
	21%	**26%**	**43%**	**10%**	**100%**	**100%**
Total - Facilities with a User Fee System:		**295**	**485**	**115**	**895**	
		33%	**54%**	**13%**	**100%**	

[6] For ease of exposition, hereafter the Matenal-Infant Clinics, CLIPERs and Dental Student Clinics will be combined with the CESAMOs.

suggests that the user fee revenue data that is available—and which includes only the revenues of Iss—may seriously under-report total UFS revenues.[7]

3.2.4 The Prevalence of UFS by Region

Table 3 shows the numbers and types of UFSs by region. There is significant regional variation in the prevalence of user fee systems. Whereas in Region 5, Copan, only 42 percent of facilities have a UFS, in both Region 4 (Choluteca) and Region 6 (La Ceiba) 98 percent have one. Region 4 also has the largest absolute number of UFSs, 183, and accounts for 21 percent of all UFSs in the country.

Another significant regional difference is in the number and proportion of UFSs that are community systems. In four of the regions—San Felipe, Choluteca, La Ceiba and Juticalpa—community systems are the predominant form of user fee systems. In stark contrast, in Metropolitana and Copan, there are no such systems. What might account for these marked differences will be explored in the following chapters. It may be that this is a manifestation of differences in regional offices' approaches to user fee systems, in general, and, specifically in how they define a community system, which is consistent with the very administrative and supervisory systems that have been established by the individual regional offices (and which will be discussed below). Given the amount of discretion the RFRM gives regional offices in their management of user fees, it is not surprising that, in effect, each regional office has developed a somewhat unique system. The key findings from the inventory—the systematic variation in the types of UFSs found in different types of facilities, and the marked variation in the number and mix of UFSs by region—prompted stratifying the sample of facilities to be surveyed by region, type of facility and type of user fee system. (See Annex A for a complete description of the development of the sampling frame and the planned and actual samples).

[7] This finding prompted the oversampling of the facilities with community systems in order to be able to provide more precise information about this type of little known system and particularly its revenues.

Table 3
The User Fee System Inventory:
Number and Type of User Fee System by Regional Location

	Region	Has No UFS	Institutional System	Community System	Both IS & CS	All Facilities	Facilities with At Least One UFS
0	Metropoliana	17	29	0	0	46	29
		37%	63%	0%	0%	100%	3%
1	San Felipe	12	23	89	18	142	130
		8%	16%	63%	13%	100%	15%
2	Comayagua	33	36	69	20	158	125
		21%	23%	44%	13%	100%	14%
3	San Pedro Sula	62	37	37	42	178	116
		35%	21%	21%	24%	100%	13%
4	Choluteca	4	40	138	5	187	183
		2%	21%	74%	3%	100%	21%
5	Copan	96	64	0	6	166	70
		58%	39%	0%	4%	100%	8%
6	La Ceiba	3	38	68	12	121	118
		2%	31%	56%	10%	100%	13%
7	Juticalpa	6	28	84	12	130	124
		5%	22%	65%	9%	100%	14%
8	Puerto Lempira	na	1	na	na	1	
	Total	**233**	**295**	**485**	**115**	**1128**	**889**
		21%	**26%**	**43%**	**10%**	**100%**	**100%**

4. The Structure and Operations of the User Fee Systems

4.1 Introduction

The analysis of the survey data in this chapter and throughout the report will follow a standardized, four-part approach. Initially, the general findings will be discussed. Then three lines of inquiry will be followed. First, in order to understand how the performances of the institutional and community systems differ, the analysis will be disaggregated by type of user fee system. Second, in order to be able to investigate how important the regional offices have been in shaping the structure and performance of the systems, the analysis will also be disaggregated by region. Since the national and regional hospitals generally operate largely independent of the regional office, whenever the performances of regions are examined, the analysis will include only the area hospitals, CESAMOs and CESARs. The third line of inquiry will be to disaggregate the analysis by type of facility.

4.2 General Description of the Sample

One hundred eighty-five of the 186 facilities surveyed reported having a user fee system. Table 4 presents the regional location of the facilities surveyed and the type of user fee system they operate.

Table 4
The Sample of User Fee Systems
by Type of System and Region

Region	Institutional System (IS)	Community System (CS)	Mixed	Total Systems Number	Total Systems Percent
0 Metropolitana	10			10	5%
1 San Felipe	3	15	7	25	14%
2 Comayagua	13	12		25	14%
3 San Pedro Sula	19	7	2	28	15%
4 Choluteca	27	2	2	31	17%
5 Copan	16	2		18	10%
6 La Ceiba	14	12	1	27	15%
7 Juticalpa	1	16	3	20	11%
8 Puerto Lempira	1			1	1%
Nation-wide	104	66	15	185	100%
Percent	56%	36%	8%	100%	

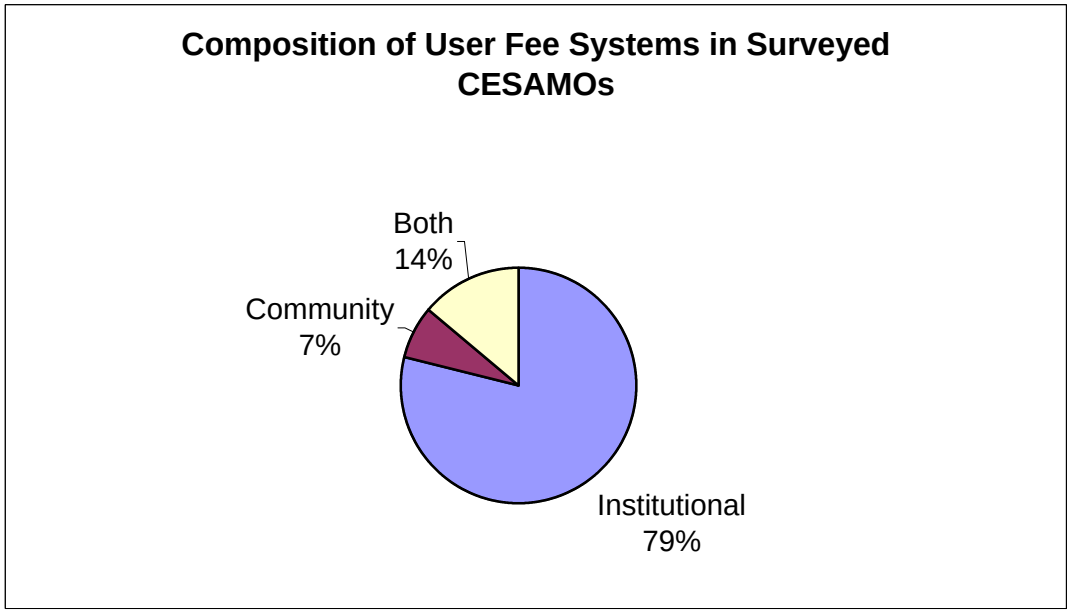
The institutional system was by far the most common, and was found in 56 percent of all of the surveyed facilities. Community systems accounted for 36 percent, with mixed systems constituting the remaining eight percent.

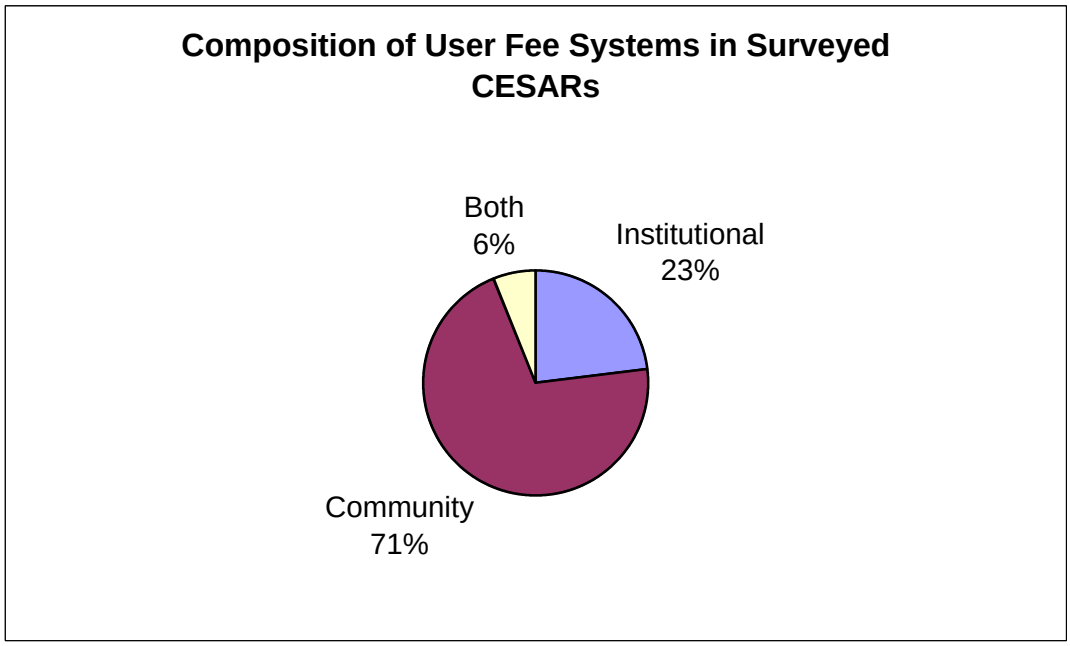
The type of UFS operated varies systematically with the type of facility. All of the hospitals—national, regional and area—operate institutional systems. In contrast, as Figure 2 shows, CESAMOs and CESARs both contain all three types of systems. Seventy-nine percent of the UFSs in CESAMOs in the sample were institutional systems, in contrast to only 23 percent of the CESARs. The majority of CESARs, 71 percent, had community systems. The combination of community and institutional UFSs was more common in CESAMOs than CESARs, 14 and 6 percent, respectively.

Given the fact that most CESARs have community UFSs and most CESAMOs have institutional UFSs, most of the regional variation in the type of UFS is due to variation in the composition of facilities in the sample: regions with a large proportion of community systems are generally regions in which a large proportion of the facilities sampled were CESARs. The only region that had a distinct mix of UFSs was Juticalpa. It did not have a purely institutional system in any of four CESAMOs or 15 CESARs surveyed. Sixteen of its 19 non-hospital facilities had community systems, and the remainder were mixed systems.

The high correlation between type of system and type facility is important to bear in mind throughout this report. Generally when the discussion focuses on community systems the facilities involved are CESARs.

Figure 2:
Composition of User Fee Systems by Type of Facility





4.3 Longevity

Ninety-one percent (168) of the 185 facilities surveyed answered the question about when their user fee system was started. The mean age of the user fee systems surveyed was 9.5 years and the median was 8.0. As Table 5 shows, 10 percent of the systems surveyed were begun prior to 1980, and only slightly more than one-quarter were initiated before 1990. The most active period of UFS start-facility was from 1990 to 1994, when 52 percent of them were initiated. This is probably due in large part to the impetus provided by the RMRF, which became law in late 1989.

The table also shows that the institutional systems are significantly older than either the community or mixed systems. The mean age of an institutional system is 13.3 years, compared to about 5 for the other two types of systems. Both the community and mixed systems are of a relatively much more recent vintage, with more than half (59 and 53 percent, respectively) of both types of systems having been started within the past three years, since 1997.

Table 6 provides more disaggregated analyses of the longevity of the UFSs. Implementation of the systems has started at the top and moved down the pyramidal referral network of the MOH; from the national hospitals, to the regionals and then the area hospitals, followed by the CESAMOs and most recently the CESARs. As measured by the mean, each type of FACILITY, with the exception of CESARs, has had a UFS for at least a decade. Again, there is circumstantial evidence of the impact of the RMRF's passage into law: the average CESAMO initiated its system the same year, 1989.

The lower portion of Table 6 presents the age of the systems by region, and includes only the facilities that the regional offices have jurisdiction over; viz., area hospitals, CESAMOs and CESARs. On average, the oldest systems are those of the regions of Copán, La Ceiba and San Pedro Sula, each of which averages a decade or more. The youngest systems are those of San Felipe, Choluteca and Juticalpa, which have been in operation an average of about five years. Table 7 provides a closer look at the CESAMOs and CESARs longevity by region and type of system. The CESAMOs' systems, which are much more likely to be institutional UFSs, on average are twice as old as those of the CESARs'. (Whether there is any systematic relationship between the age of a UFS and how it is structured and how it functions is investigated below.)

Table 5
The Founding Year and Average Age of User Fee Systems by Type

	Type of User Fee System				*All UFSs in the Sample*	
Founding Year	**Institutional**	**Community**	**Mixed**	**All**	**Percent**	**Cumulative Percent**
Pre 1970	7	0	0	7	4%	4%
During the 1970s	11	0	0	11	6%	10%
During the 1980s	24	6	2	32	17%	27%
1990 to 1994	27	15	4	46	25%	52%
1995	1	6	2	9	5%	57%
1996	7	0	0	7	4%	61%
1997	5	10	4	19	10%	71%
1998	5	12	2	19	10%	81%
1999	4	13	2	19	10%	91%
2000		1	0	1	1%	92%
Uncertain	11	3	1	15	8%	100%
Total:	102	66	17	185	100%	
Average Age:						
1) Mean	13.3	4.9	5.5	9.5		
2) Median	10.0	3.0	3.0	8.0		

Table 6
The Average Age of User Fee Systems by Region and Type of Facility

Type of Facility	Number of Systems	*Average Age* Mean	Median
National Hospital	6	26.2	24.5
Regional Hospital	5	26.0	20.0
Area Hospital	16	15.3	8.3
All Hospitals	27	19.7	20.0
CESAMOs	68	10.1	8.0
CESARs	73	5.2	3.0

Region*	Number of Systems	*Average Age* Mean	Median
Metropolitana	5	9.0	8.0
San Felipe	24	5.1	3.0
Comayagua	24	7.3	5.5
San Pedro Sula	26	11.3	9.5
Choluteca	20	5.5	4.0
Copan	17	13.0	10.0
La Ceiba	25	11.0	10.0
Juticalpa	15	3.7	2.0
Puerto Lempira	1	12.0	12.0
Total:	157	8.3	7.0

*Region: Includes only Area Hospital, CESAMOs and CESARs.

Table 7
Median Age of User Fee Systems
by Type of System, Type of Facility and Region
Includes Only CESAMOs and CESARs

Region	Institutional System (IS)	Community System (CS)	Mixed	All Types
Metropolitana				
CESAMO	9.5			9.5
CESAR	8			8
San Felipe				
CESAMO	4	1	3	3
CESAR		2.5	13	3
Comayagua				
CESAMO	6.5	1		5
CESAR	7.5	5		5
San Pedro Sula				
CESAMO	11		7	10.5
CESAR			3	2.5
Choluteca				
CESAMO	8	3		8
CESAR	2	2	3.5	2
Copan				
CESAMO	17			17
CESAR		9		9
La Ceiba				
CESAMO	8		18	9
CESAR		7.5		7.5
Juticalpa				
CESAMO		6	1.5	2
CESAR		2		2
The Entire Sample				
CESAMO	11.5 (n=54)	2.8 (n=4)	5.4 (n=10)	10.2 (n=68)
CESAR	5.1 (n=10)	5.1 (n=59)	5.8 (n=4)	5.2 (n=73)

4.4 Knowledge About the Legal Framework of User Fees, the RMRF

Only about one quarter of the surveyed facilities' respondents acknowledged that they were aware of the RMRF. Eighty-two percent of those who were aware of the *Regulation*, had a copy of the document. In other words, only 22 percent of the facilities that were surveyed had a copy of the the RMRF. As may be seen in Table 8, the higher the level of the facility, the more likely its staff was aware of the *Regulation* and to have a copy of the Manual. Eighty-nine percent of the hospitals' respondents knew of the *Regulation*, compared to about one-third of the CESAMOs and only one (1 percent) of the 86 CESARs. Whereas 86 percent of the hospital respondents had a copy of the RMRF, the same was true of less than a quarter (23 percent) of the CESAMOs. Not one of the 86 CESARs surveyed had a copy of the *Regulation*.

Table 9 presents only the regional office facilities' responses to the same questions as that provided in the preceding table. Only one-fifth of the surveyed facilities know about the *Regulation* and only one-sixth (16 percent) of them have a copy of the Manual. Again, among those that are aware of the *Regulation*, a high proportion, 76 percent, were able to show the interviewer a copy of the document. Generally there is an inverse relationship between a region's average user fee system age and its knowledge of the *Regulation*. The regions that have the younger systems —Juticalpa, Choluteca and San Felipe—have the greatest ignorance about the *Regulation*, while the regions with the oldest systems—San Pedro Sula, Copán and La Ceiba—have relatively higher levels of awareness of the legal document. Still, the level of awareness about the RMRF is low throughout the system. Clearly, there is a need to do a better job of informing the regional offices and facilities about the legal framework governing the structure and operations of user fee systems and to provide them with a copy of the document.

Facilities with community UFS are almost universally ignorant about the RMRF. Although most of the detail of the RMRF pertains to the structure and operations of an institutional UFS, it also provides important information about the general rules and Regulations governing community systems. For facilities with community systems not to have any knowledge about the Manual suggests that there is a high probability that they are operating their systems in a manner that is not in concordance with the *Regulation*.

Ten of the respondents who were not aware of the RMRF reported that there was a manual explaining the management of the UFS. These facilities operate a UFS that is distinct from that of the IS described by the RMRF. The fact that there exists a distinct manual governing the operations of these systems suggests that they are formalized structures.

Table 8
Knowledge About and Possession of
The Use of Recovered Funds Regulation and Manual (RMFR)
by Type of Facility and Type of User Fee System

(A) Type of User Fee System or Facility	(B) Number of Respondents	(C) *Aware of the RMFR?* Yes	(C) *Aware of the RMFR?* No	(D) *Does the Facility Have a Copy of the RMFR?* YES: As % of All Respondents (Col. B)	(D) YES: As % of Those Rptg There is a Manual	(D) NO: As % of Those Rptg There is a Manual
Institutional UFS	104	44 42%	54 52%	39 38%	39 89%	5 11%
Community UFS	66	1 2%	65 98%	0 0%	0 0%	1 100%
Mixed UFS	15	4 27%	11 73%	1 7%	1 25%	3 75%
Hospitals	28	25 89%	3 11%	24 86%	24 96%	1 4%
CESAMOs	71	23 32%	48 68%	16 23%	16 70%	7 30%
CESARs	86	1 1%	85 99%	0 0%	0 0%	1 100%
The Entire Sample	185	49 26%	136 74%	40 22%	40 82%	9 18%

Table 9
Knowledge About and Possession of
The Use of Recovered Funds Regulation and Manual (RMFR)

by Region (Includes Only Area Hospitals, CESAMOs and CESARs)

(A) Type of User Fee System or Facility	(B) Number of Respondents	(C) *Aware of the RMFR?* Yes	(C) *Aware of the RMFR?* No	(D) *Does the Facility Have a Copy of the RMFR?* YES: As % of All Respondents (Col. B)	(D) YES: As % of Those Rptg There is a Manual	(D) NO: As % of Those Rptg There is a Manual
Metropolitan	5	3 60%	2 40%	2 40%	2 67%	1 33%
San Felipe	25	5 20%	20 80%	2 8%	2 40%	3 60%
Comayagua	24	6 25%	18 75%	6 25%	6 100%	0 0%
San Pedro Sula	26	10 38%	16 62%	6 23%	6 60%	4 40%
Choluteca	30	3 10%	27 90%	3 10%	3 100%	0 0%
Copan	17	4 24%	13 76%	4 24%	4 100%	0 0%
La Ceiba	26	5 19%	21 81%	4 15%	4 80%	1 20%
Juticalpa	19	0 0%	19 100%	0 0%		
Puerto Lempira	1	1 100%	0 0%	1 100%	1 100%	1 100%
The Entire Sample	173	37 21%	136 79%	28 16%	28 76%	10 27%

4.5 Elements of the Administrative Systems

4.5.1 The Fee Collector

Table 10 shows who collects user fees in the facilities. The two most common arrangements are for this duty to be carried out by nurse auxiliaries and cashiers (50 and 31 percent, respectively). The institutional UFSs follow this general pattern, dominated by nurse auxiliaries and cashiers, but the community systems are quite distinct. While nurse auxiliaries are the principal type of collector in the CSs as well, the health committee collects the monies in 25 percent, and less than five percent have dedicated cashiers positions. Nearly all the health committees' fee collectors are in CESARs. Three CESARs reported that nobody collects the fees; that people simply put whatever they can afford to contribute into a box or urn.

Eighty percent of the persons collecting user fees are paid employees of the Ministry of Health. The most common arrangement is that found in half of the surveyed facilities, where they are doing double duty as a health care provider (generally a nurse auxiliary) and as the fee collector. The proportion of fee collectors who are MOH employees varies greatly by type of facility. It is 100 percent in the hospitals, 92 percent in the CESAMOs and 59 percent in the CESARs. Most of the CESARs in which the collectors are not MOH staff have either community or mixed user fee systems. In these systems, 41 percent are volunteers and 30 percent are employees of the health committee.

Table 10
Staff-person or Agent Who Collects the User Fee Revenues

	Number of Respondents	Nurse Auxiliary	Cashier	Health Committee	General Assistant	Others
Type of UFS						
Institutional	104	42	54		1	7
Community	66	40	2	15	7	2
Mixed	15	10	2	1	1	1
	185	92	58	16	9	10
Type of Facility						
National Hospital	6		6			
Regional Hospital	6		6			
Area Hospital	16		16			
All Hospitals	28		28			
CESAMOs	71	37	27	2		3
CESARs	86	55	3	14	9	5
All Facilities	**185**	**92**	**58**	**16**	**9**	**8**
	100%	50%	31%	9%	5%	4%

4.5.2 Institutional User Fee Systems and Regional Office Oversight

The routine method of handling the revenues varies by type of UFS. Table 11 shows what is done in institutional systems, and Table 12 presents the community systems' approaches. In 63 percent of the ISs, the regional office directly manages at least a portion of the fees, either picking them up from the facility or the facility brings them to the regional office. The percent of total revenues and the regional offices manage (pick up from the facilities or that the facilities deposit with the regional offices) varies significantly, sometimes even within the same region. The bulk of the remaining facilities, reported they either deposit them in a bank account or spend them.

While the primary reason for visiting the UPSs and Areas is to pick up their user fee revenues, some of the RO personnel report that they visit UPSs in order to facilitate the exchange of fully used receipt books for new ones (which can be cumbersome in the busier, more productive facilities). All of the ROs that visit UPSs or Areas said that they take advantage of their trips to undertake other activities related to the UFSs, as well, such as:

- Obtaining price bids for the facilities,
- Supervising management of the user fee revenues,
- Restocking some of the supplies of the facility, and
- Undertaking an inventory.

Seven of the ROs reported that all of the UPSs in their domains adhered to the Manual-stipulation that all institutional user fee revenues be turned over to the Regional Office each month. The individual facilities' responses, however, indicated otherwise. The frequency with which the submissions are made also varies. In Region 6, La Ceiba, the monies are submitted only once every six months and in San Pedro Sula they are submitted on a bi-monthly basis.

Seventeen of the hospitals, including all of the national hospitals, do not submit their monthly earnings to their respective Regional Offices. They retain and manage all (100 percent) of their own fee revenues, independently, although they do submit reports of their flow of user fee funds. The CESAMOs' fees are usually handled by the regional office. Eighty percent of the CESARs with institutional user fee systems—all of which are located in Choluteca Region (n=7)—reported that they manage their user fee revenues, without regional office oversight and spend their revenues on facility needs.

Eight of the regional office interviewees reported that their office returns the institutional user fee revenues to the facility as set forth in the Manual. The ninth RO said that it returned more than the Manual-stipulated 75 percent to each UPS because of the large number of requests that it had received to do so. Seven of the ROs reported that the remainder of the institutional user fee revenues is used to support beneficiaries of the regional MOH network. Three of these seven respondents said their offices spend the Region's 25 percent share of revenues on materials that are then distributed throughout the network in-kind. (The expenditures of these monies are discussed in Chapter 5.)

Table 11
Administration of the Institutional User Fee System Revenues

Characteristic	Number of Respondents	Regional Office Picks Them Up	UPS Takes Them to the Reg'l Office	Spends Them on the UPS's Needs	Deposits Them in Bank Acct.	Sends Them to Health Area Office
Type of Facility						
National Hospital	6				6	
Regional Hospital	6	1	2		3	
Area Hospital	16	3	5	1	7	
All Hospitals	28	4	7	1	16	
CESAMOs	66	37	23	1	3	2
CESARs	25	2	2	20		1
Region*						
Metropolitana	5	1			3	1
San Felipe	10	1	8		1	
Comayagua	12	6	5	1		
San Pedro Sula	19	11	3		4	1
Choluteca	28		8	20		
Copan	15	13	2			
La Ceiba	14	9	3	1	1	
Juticalpa	3	1	1			1
Puerto Lempira	1				1	
All Regions	**107**	**42**	**30**	**22**	**10**	**3**
All Facilities	**119**	**43**	**32**	**22**	**19**	**3**
		36%	**27%**	**18%**	**16%**	**3%**

Table 12
Administration of the Community User Fee System Revenues

Characteristic	Number of Respondents	Health Committee Picks Them Up	UPS Takes Them to the Health Committee	Spends Them on the UPS's Needs	Deposits Them in Bank Acct.	Other
Type of Facility						
National Hospital	0					
Regional Hospital	0					
Area Hospital	0					
All Hospitals	0					
CESAMOs	16	4	2	7	1	2
CESARs	65	21	7	31	2	4
Region						
Metropolitana	0					
San Felipe	23	9	7	6	1	
Comayagua	12	5		6	1	
San Pedro Sula	9		1	7		1
Choluteca	4	1		2		1
Copan	2			1		1
La Ceiba	13	10	1	1		1
Juticalpa	18			15	1	2
Puerto Lempira	0					
All Regions	**81**	**25**	**9**	**38**	**3**	**6**
All Facilities	**81**	**25**	**9**	**38**	**3**	**6**
		31%	**11%**	**47%**	**4%**	**7%**

4.5.3 Community User Fee Systems and Health Committee Oversight

Table 12 shows the types of administrative systems governing the functioning of the community systems. In many of these systems, the health committee assumes a role that is very similar to that of the regional office in the institutional system, although the arrangement is less prevalent. The most common arrangement reported in the community systems is that the funds are spent on the facilities' needs. The next most common arrangement was for the health committee to directly manage the funds, with CSs either taking their revenues to the health committee or the committee routinely picking them up. This type of system characterized 42 percent of the facilities surveyed that have community user fee systems. In most of these instances (82 percent), the facility is a CESAR. The remaining facilities are CESAMOs. Nearly 80 percent of the facilities in which the health committees play this role are located in just two regions, San Felipe and La Ceiba. In both of these regions, this type of arrangement characterizes the vast majority of facilities with community systems (70 and 85 percent, respectively).

4.5.4 Responsibilities for Managing User Fee Income within the Health Facilities

The agent responsible for the appropriate handling of the revenues (termed the "managers") is shown in Table 13. They vary substantially by type of UFS and even within the same type of system in terms of who is responsible, as well as whether there is a single individual responsible or the revenues are jointly managed. In the IS the most common arrangement, characterizing only 30 percent of the total, is for the director of the facility to be the responsible agent. In the CSs, there is less variability. It is usually the health board (56 percent) or the nurse auxiliary (31 percent) that is the manager. It is interesting to note that in two facilities the municipal government is the manager of the UFS revenues.

Who determines how the user fee income are spent is shown in Tables 14 and 15. The primary authority in the ISs is the facility director and in CSs it is the health committee. In both ISs and CSs, nurse auxiliaries are the next most frequently involved agent, as either a primary or secondary decision-maker. In the hospitals the primary authority is the director and the administrator generally has secondary authority. In the other types of facilities, there is more variability. In CESAMOs it is usually (59 percent) the facility director, whereas in CESARs the nurse auxiliary is usually the decision-maker (57 percent), followed by the health committee (34 percent). Even in CESARs with CSs, it is more commonly the nurse auxiliary than the committee who decides how to spend the money.

Table 13
Managers of the User Fee Revenues

	Total Responses		Sole Managers		Joint Managers	
Institutional UFS Manager	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Director UPS	45	30%	21	14%	24	16%
Administrator	35	23%	11	7%	24	16%
Nurse, Nurse Auxiliary	37	25%	30	20%	7	5%
Physician	24	16%	21	14%	3	2%
Cashier	6	4%	2	1%	4	3%
Regional Office	2	1%	2	1%		
Health Area Chief	1	1%	1	1%		
Total	**150**	**100%**	**88**	**59%**	**62**	**41%**

	Total Responses		Sole Managers		Joint Managers	
Community UFS Manager	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Health Board	36	40%	27	30%	9	10%
Nurse Auxiliary	28	31%	21	24%	7	8%
Health Board Treasurer	12	13%	9	10%	3	3%
Nurse	5	6%	1	1%	4	4%
Nurse Auxiliary and Health Board	2	2%	2	2%		0%
Municipal Government	2	2%	1	1%	1	1%
Community Personnel	1	1%	1	1%		
Cashier	1	1%			1	
Director UPS	1	1%	1	1%		0%
Don't Know	1	1%	1	1%		0%
Total	**89**	**100%**	**64**	**72%**	**25**	**28%**

Table 14
Who Determines How the User Fee Revenues Are Spent
By Type of User Fee System

Position	Total Responses		Primary Authority		Secondary Authority	
	Number	Percent	Number	Percent	Number	Percent
Institutional Systems						
Facility Director	75	40%	67	36%	8	4%
Regional Office	8	4%	7	4%	1	1%
Facility Administrator	39	21%	16	9%	23	12%
Accountant	2	1%	1	1%	1	1%
Nurse Auxiliary	60	32%	27	14%	33	18%
Cashier	3	2%	2	1%	1	1%
Total	187	100%	120	64%	67	36%
Community Systems						
Facility Director	14	11%	7	6%	7	6%
Health Committee	55	44%	36	29%	19	15%
The Patronato	1	1%	1	1%		0%
Nurse Auxiliary	55	44%	32	25%	23	18%
Municipality	1	1%	1	1%		0%
Total	126	100%	77	61%	49	39%

Table 15
Who Determines How the User Fee Revenues Are Spent
By Type of Facility
Persons with Primary Authority

Position	Total Responses		Institututional UFSs		Community UFSs	
	Number	Percent	Number	Percent	Number	Percent
CESAMOs						
Facility Director	47	59%	43	54%	4	5%
Regional Office	7	9%	7	9%		
Administrator	8	10%	8	10%		
Health Committee	7	9%			7	9%
Nurse Auxiliary	10	13%	8	10%	2	3%
Municipality	1	1%			1	1%
Total	80	100%	66	83%	14	18%
CESARs						
Facility Director	4	5%	1	1%	3	3%
Health Committee	29	34%			29	34%
The Patronato	1	1%			1	1%
Nurse Auxiliary	49	57%	19	22%	30	35%
Cashier	3	3%	2	2%	1	1%
Total	86	100%	22	26%	64	74%

4.6 User Fee Levels / Prices

The discussion of user fees will initially review the legal foundation of user fee prices, the RFRM. Then it will examine the structure of established fees. Next, in Sections 4.7 and 4.8, exoneration policies and practices are examined. The likelihood of having to pay for care is discussed in Section 4.9 and 4.10 investigated the average effective user fee general consultation rates. (An average effective user fee is the set price of a service multiplied by the number of such services provided minus any exonerations, partial exemptions and any other reasons for non-collection or non-reporting.)

The RFRM presents a very specific, differentiated system of fees that are to be charged in each type of facility:

- a single fee for a consultation in a CESAR of 50 centavos
- an outpatient fee of one lempira in a CESAMO, along with five other fees for those CESAMOs with dental, laboratory and radiology services, and
- an outpatient fee one lempira along with eight other different fees in Area and Regional Hospitals, and 16 service fees in national hospitals.

The Manual specifically states that the fee charged for outpatient consultations and dental visits in hospitals and CESAMOs does not include use of the services of hospitalization or of any support services (radiology, laboratory, etc.). By implication, additional fees may be charged for these services, and indeed the fee structure set forth in the Manual identifies additional specific charges for particular support services.

4.6.1 Price Differentiation: The Number of Services with Their Own Distinct Price

The prices of all services provided at each facility were collected during the survey. There was great diversity in the number of services for which prices were charged. In the 185 facilities surveyed that have user fees, 301 different services were charged for by one or more facilities.[8] Forty-seven percent of the 301 different services were charged for in only one facility. Another 52 services had separate charges in only two facilities. Eighty-two percent of the 301 services were charged for in 5 or fewer facilities. At the other extreme, 98 percent of the surveyed facilities had a fee for a general consultation.

Not surprisingly, the degree of price differentiation varied systematically with the type of facility and by type of user fee system. The community user fee systems were far more simple, and generally consisted of a single, all inclusive fee charged for consultations. As Table 16 shows, this was the case with all 60 of the CESARs for which there is fee information. The mean number of community system prices in CESAMOs was 1.3 . Both the mean and the median number of prices in the regions was 1.0.

[8] A large fraction of the total number of different prices was due to different types of x-rays and different types of laboratory tests for which specific, distinct fees were assessed. See Annex C for a complete listing.

Table 16
The Degree of Price Differentiation in MOH Facilities: Number of Distinct Prices the Facility Charges for Services

Community User Fee Systems Only

Characteristic	Number of Respondents	Number of Prices	
		Mean	Median
Type of Facility			
National Hospital	0		
Regional Hospital	0		
Area Hospital	0		
All Hospitals	0		
CESAMOs	6	1.3	1.0
CESARs	60	1.0	1.0
All Facilities	**66**	**1.0**	**1.0**
Region*			
Metropolitana	0		
San Felipe	15	1.1	1.0
Comayagua	12	1.0	1.0
San Pedro Sula	7	1.1	1.0
Choluteca	2	1.0	1.0
Copan	2	1.0	1.0
La Ceiba	12	1.0	1.0
Juticalpa	16	1.5	1.0
Puerto Lempira			
Regions' Total	**66**	**1.0**	**1.0**

The institutional user fee systems had a mean of 9.3 and a median of 2.0 prices per facility. As may be seen in Table 17, here too the CESARs' fee structures were the simplest, with a mean of 1.3 prices and a median of one per facility. CESAMOs had a mean that was twice this level, 2.7, but their median was also 1.0. The degree of price differentiation in the hospitals was substantially greater, and within the sector it varied in a manner that was counterintuitive. The area hospitals had the most complex fee structures, with a mean of 42 different prices, compared to 24 for regional hospitals and just 16 for the national hospitals. While the median numbers of prices were considerably more similar—reflecting the fact that two area hospitals had especially highly differentiated fee systems (both with in excess of 90 distinct fees)—the ratio of the area hospitals' median to that of the nationals' was still substantial, nearly two-to-one.

4.6.2 Price Variations 1-- Variations Across Types of Facilities: An Efficiency Issue

A number of criteria were developed in order to provide a more manageable number and a more meaningful set of comparisons of fees across the five different facility types. Initially, the most common types of the 301 services for which there are differentiated institutional user fees were identified for each type of facility. Next, so as to ensure that the comparisons across facilities would not capture the potentially seriously distorting influence of a single outlier facility, there had to be a minimum of two observations; i.e., at least two facilities of the particular type in question had to charge a distinct fee for that service. A final criterion that figured into the development of the relative prices was that at least two different types of facilities had to have distinct fees for the service in question. Applying these criteria resulted in identifying 18 different services that will be used to make across facility type comparisons of institutional user fee levels.[9]

Table 18 presents the average (mean) prices for each type of facility for each type of service, fulfilling the criteria earlier discussed. In general, the fee levels are low. There is, however, considerable variation in their levels across facility types. The far right-hand column of the table presents the MOH all facilities average fee for each service. This average is calculated across the entire sample of facilities reporting institutional user fee levels (n = 119). This column represents the average price charged by the MOH for the 18 most common types of services for which there are differentiated institutional user fees.

The single quantitatively most important fee is that of the most common service, a general consultation. The MOH average (mean) general consultation fee is 2.0 lempiras, and the fee ranges from a low in national, non-psychiatric hospitals of 1.0 lempira to a high in the 16 area hospitals of 3.1 lempiras.[10] Graph 3 shows how the average price of a general consultation in six different types of MOH facilities varies. The national hospitals fee is the lowest, followed by a CESAMO. The regional hospitals' average general consultation fee is the highest, followed closely by that of area hospitals' average. The same general relative price structure characterizes specialty consultations, as well, as may be seen in Graph 4. Non-psychiatric, national hospitals' average specialty consultation fee is less than half of the MOH wide average. In terms of the incentives provided to would-be patients, the relative price structure of a MOH general and specialty consultations are problematic.

[9] See Annex C, Table C-2 containing the number of facilities with a fee for each of the specific service types.

[10] The different nature of services in the psychiatric vis-à-vis non-psychiatric national hospitals, together with their very different fee structures prompted their separation.

Table 17
The Degree of Price Differentiation in MOH Facilities: Number of Distinct Prices the Facility Charges for Services

Institutional User Fee Systems Only

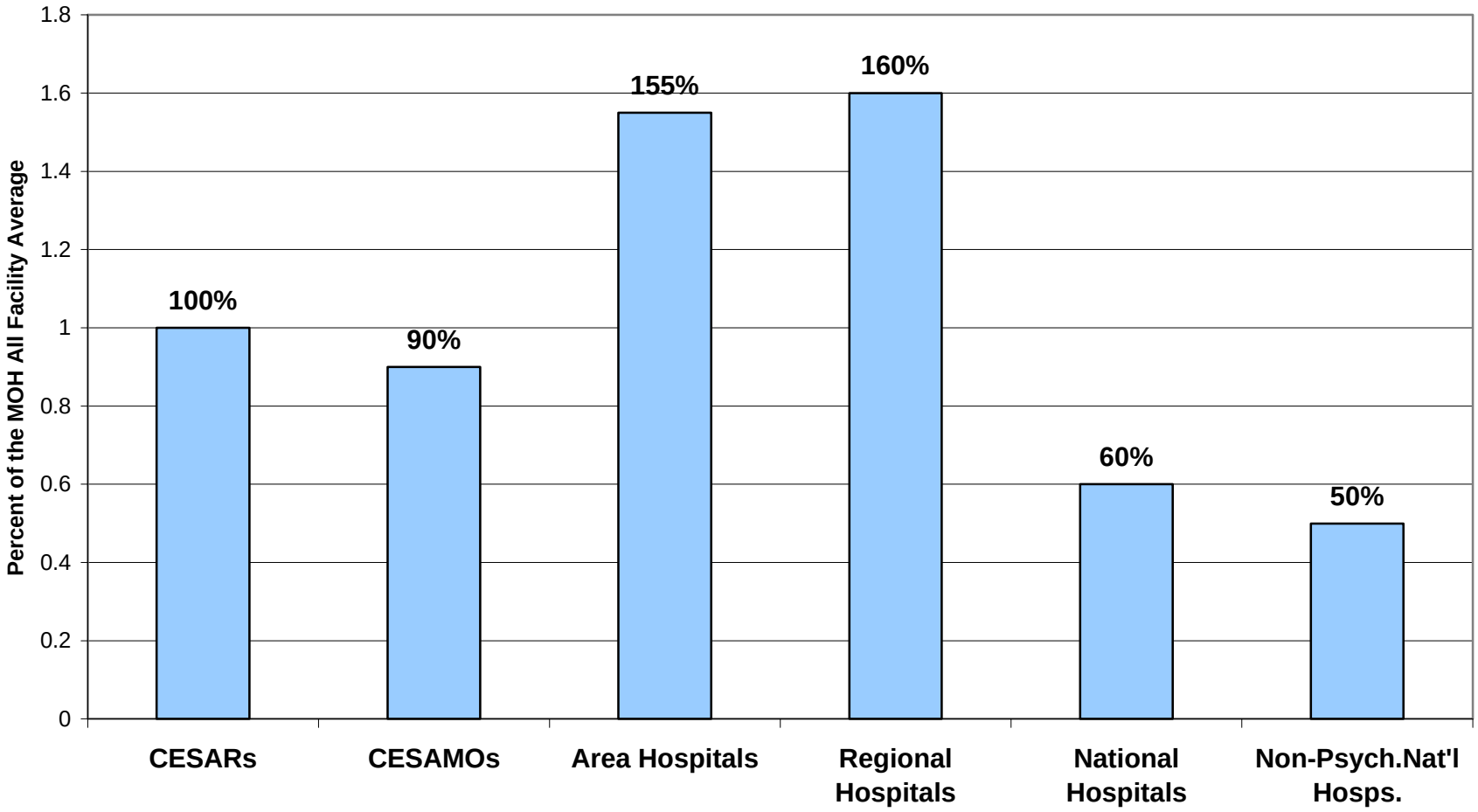
Characteristic	Number of Respondents	Number of Prices	
		Mean	Median
Type of Facility			
National Hospital	6	16.2	14.5
Regional Hospital	6	23.5	19.0
Area Hospital	16	41.8	27.5
All Hospitals	28	32.4	18.0
CESAMOs	66	2.7	1.0
CESARs	27	1.3	1.0
All Facilities	**121**	**9.3**	**2.0**
Region*			
Metropolitana	5	6.0	7.0
San Felipe	10	3.3	1.5
Comayagua	12	6.5	1.0
San Pedro Sula	21	4.3	3.0
Choluteca	28	2.6	1.0
Copan	15	13.8	1.0
La Ceiba	14	24.6	3.5
Juticalpa	3	3.7	3.0
Puerto Lempira	1	18.0	18.0
Regions' Total	**109**	**8.1**	**1.0**

Table 18
Average (Mean) Prices of the Most Common Types of Services for Which There are Differentiated Institutional User Fees*

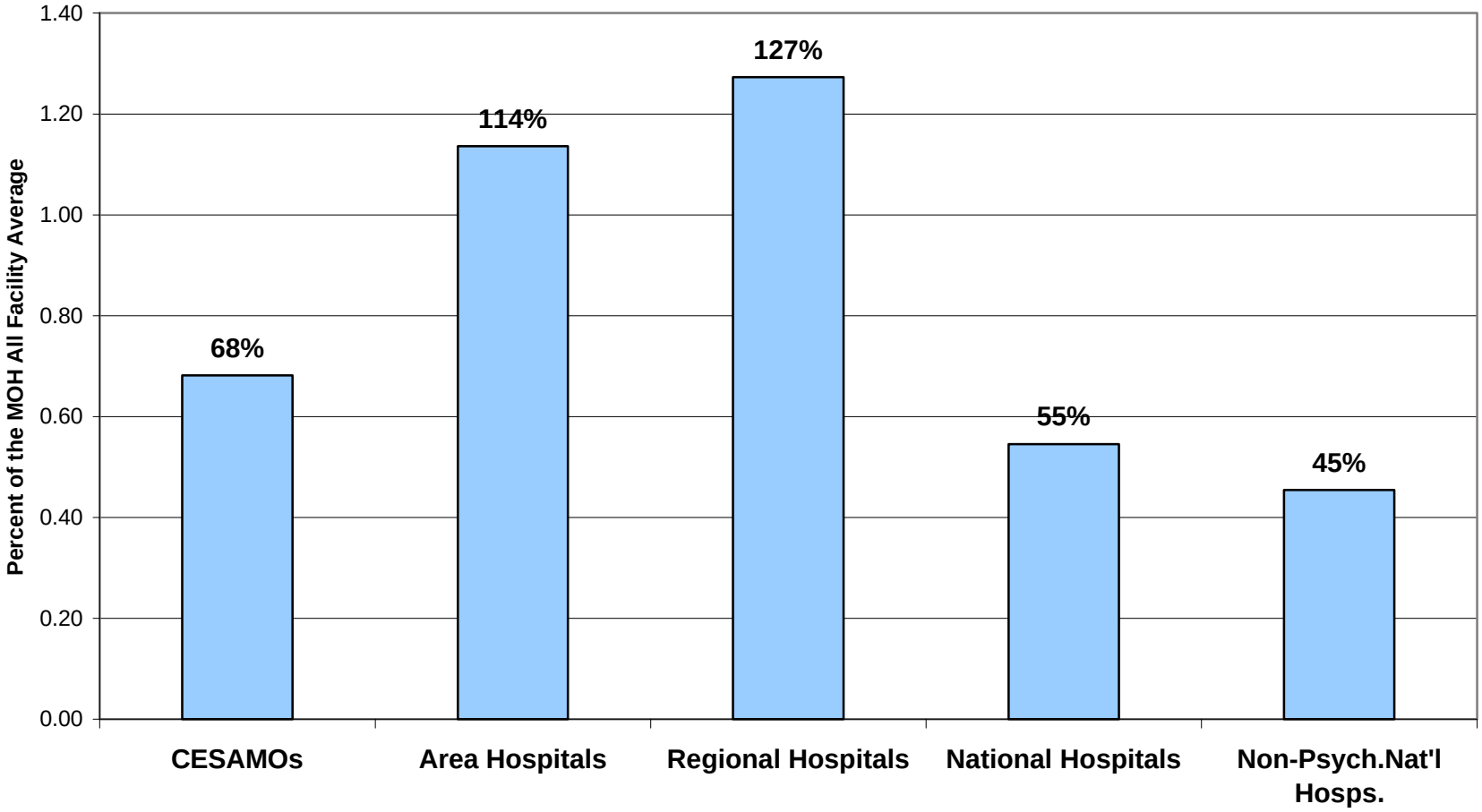
In Current Lempiras

Ranking	Service	CESARs	CESAMOs	Area Hospitals	Regional Hospitals	National Hospitals	Non-Psychiatric National Hosps.	All Facilities (Weighted Avg.)
1	General Consultation	2.0	1.8	3.1	3.2	1.2	1.0	2.0
2	Laboratory		3.5	4.2	3.4	1.8	2.0	3.5
3	Lab: Gravindex		7.1	7.0	7.0	3.0	3.0	6.7
4	Lab: VDRL		5.1	6.3	4.8	2.6	2.5	5.1
5	Dental: Extraction		6.6	7.7	8.0	13.8	19.0	8.1
6	Lab: Blood Chemistry		5.5	7.4	5.8	3.6	4.3	5.8
7	Specialty Consultation		1.5	2.5	2.8	1.2	1.0	2.2
8	X-Ray: Thorax			21.7	16.7	9.0	8.7	18.1
9	Dentistry: Cleaning		27.5	11.3	23.8	17.5	16.7	20.0
10	Pielograma			68.3	110.0	50.0	40.0	73.0
11	X-Ray: Head/Cranium			45.0	12.5	15.0	10.0	35.4
12	Dentistry: Provisional Filling		13.0	23.0	45.0	20.0	15.0	24.3
13	Birth		12.5	50.7	115.0	87.0		55.5
14	Lab: Complete Blood		4.0	5.5	5.0			5.1
15	Enema			103.8	150.0	50.0	30.0	101.9
16	Nebulizations			11.3	7.5			9.3
17	Scraping			122.0	130.0			124.3
18	Hospitalization: C-section			220.0	187.5			210.7
	Number of Facilities	25	66	16	6	6	4	119

Graph 3: Price of a General Consultation at the Different Types of MOH Facilities
Expressed as a Percent of the MOH-wide Average



Graph 4: Price of a Specialty Consultation at the Different Types of MOH Facilities, Expressed as a Percent of the MOH-wide Average



The structure of general consultation prices promotes inefficiency in provision of MOH care. It encourages patients to seek care first at national hospitals, then CESAMOs and next at CESARs. For user fee levels to be consistent with the intent, design and purpose of the pyramidal structure of the MOH infrastructure, user fees should rise as one goes up the pyramid to the more expensive, less accessible services, in order to discourage unnecessary utilization and to ration the less available, more costly care. Conversely, fees at CESARs—the base of the pyramid—should be lowest, in order to encourage entry to the MOH health care system at this least expensive, most readily available level of care. Ideally, the MOH fee structure would be lowest at CESARs and increase incrementally as one traveled up the pyramidal referral network to CESAMOs, then area hospitals, then regional hospitals and finally at the national referral hospitals. This fee setting principal is violated by the Honduran MOH facilities' user fee levels, and should be corrected. A definitive assessment of MOH user fee levels, however, must also take into account the probability of having to pay the established fee level (i.e., the proportion of patients who actually pay the full fees), as well as the equity, and other considerations. The discussion returns to this more comprehensive type of assessment below.

The relative prices of general consultations, however, are not the only fees that vary in a manner that is inconsistent with MOH policy goals and objectives. Table 19 presents an index of the average prices by type of facility for the 18 most common types of services for which there are differentiated institutional user fees in the MOH facilities surveyed. This table is constructed from the information provided in the preceding table. The entries in this table are developed on a row-by-row basis. Each row in the table is a specific type of health service. Each service's price in each type of facility in the preceding table is divided by the MOH "All Facilities" average price index in the right-hand column of the preceding table. In other words, every entry in each row in Table Prices is divided by the "All Facilities" entry and then expressed as a percentage. This calculation yields the proportion of the particular facility type's average price for the particular service in question relative to the MOH "All Facilities" average price of that service. For example, the non-psychiatric, national hospital value for General Consultation in Table 19 is 50%; which is to say, the non-psychiatric, national hospitals' average price for a General Consultation is 50% that of the MOH's "All Facilities'" average (calculated by dividing the Table Prices' entry for non-psychiatric, national hospitals of 1.0 lempira by the "All Facilities'" average of 2.0 lempiras).

The next two graphs present summaries of these comparisons of the average prices of specific types of facilities to the MOH all facilities' average price. First, an unweighted average of each type of facilities' mean price as a percent of the MOH average price is computed. (This is the arithmetic mean of each of the columns in Table 18.) The results, presented in Graph 5, show, for example, that the average price of non-psychiatric, national hospitals' services are 65 percent of the MOH-wide average service price; i.e., non-psychiatric, national hospitals' services, on average, are 35 percent lower than the MOH's all facilities' average fee.[11] For those services for which they charge, the national hospitals' average service fees are on average the lowest. At the other extreme are the regional hospitals: on average, their average fees are 115 percent of (i.e., 15 percent higher than) the MOH average fee.

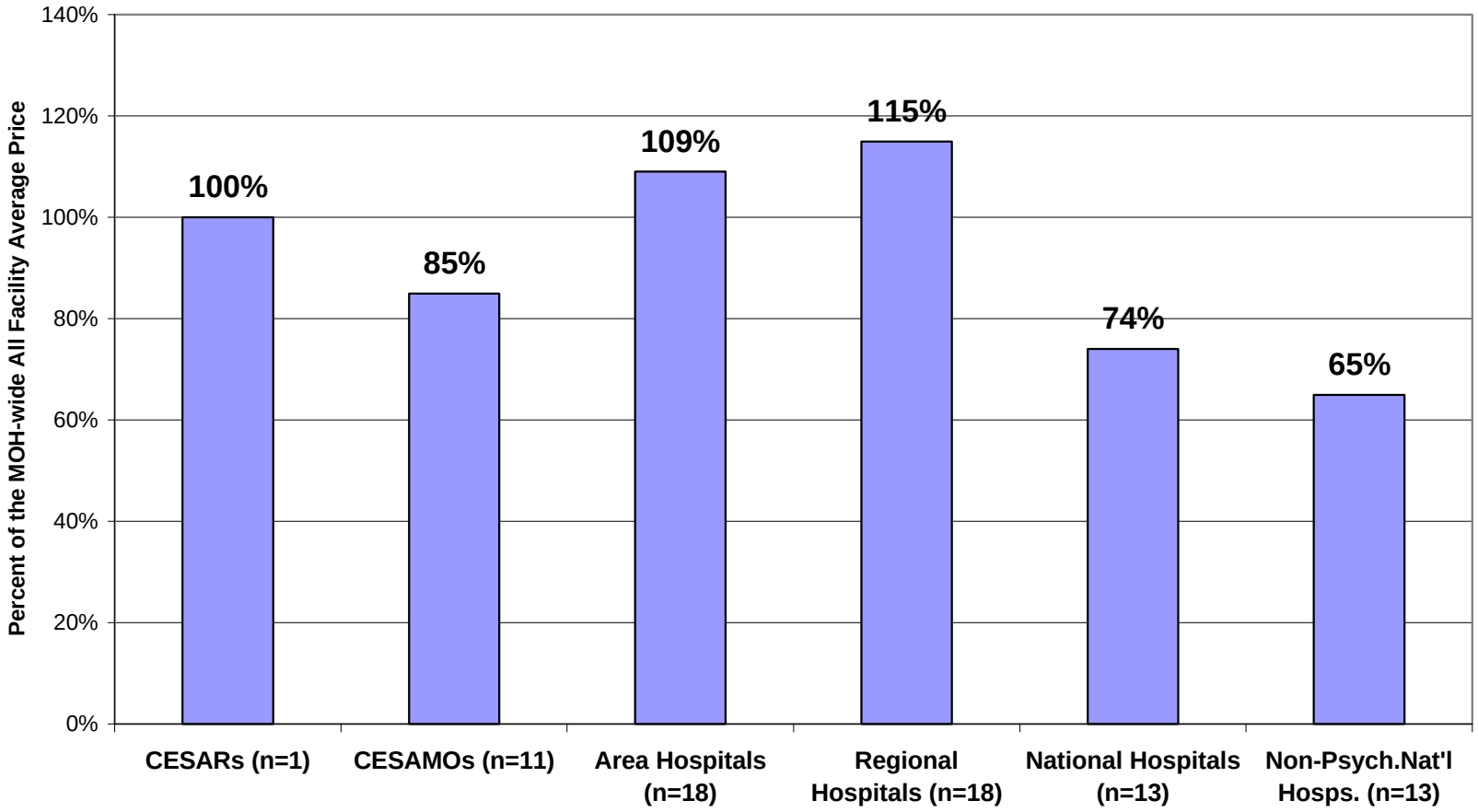
[11] The reader is reminded of the criteria that were used to develop the list of 18 services on which these analyses are based. To be included in the list a specific fee had to be charged for that particular service in at least two facilities of a particular facility type, and there had to be at least two different types of facilities in which this condition was met. The application of these criteria resulted in different numbers of services being included in the analysis for each facility type. The number of services that are included is identified as "n" in the graphs.

Table 19
The Average Prices of the Most Common Types of Services for Which There are Differentiated Institutional User Fees*

For Each Service, Each Type of Facility's Average Price is Expressed as a Percent of the MOH-wide Average Price

Ranking	Service	CESARs	CESAMOs	Area Hospitals	Regional Hospitals	National Hospitals	Non-Psychiatric National Hosps.	MOH-wide (Weighted Avg. of All Facilities)
1	General Consultation	100%	90%	155%	160%	60%	50%	100%
2	Laboratory		100%	120%	97%	51%	57%	100%
3	Lab: Gravindex		106%	104%	104%	45%	45%	100%
4	Lab: VDRL		100%	124%	94%	51%	49%	100%
5	Dental: Extraction		81%	95%	99%	170%	235%	100%
6	Lab: Blood Chemistry		95%	128%	100%	62%	74%	100%
7	Specialty Consultation		68%	114%	127%	55%	45%	100%
8	X-Ray: Thorax			120%	92%	50%	48%	100%
9	Dentistry: Cleaning		138%	57%	119%	88%	84%	100%
10	Pielograma			94%	151%	68%	55%	100%
11	X-Ray: Head/Cranium			127%	35%	42%	28%	100%
12	Dentistry: Provisional Filling		53%	95%	185%	82%	62%	100%
13	Birth		23%	91%	207%	157%		100%
14	Lab: Complete Blood		78%	108%	98%			100%
15	Enema			102%	147%	49%	29%	100%
16	Nebulizations			122%	81%			100%
17	Scraping			98%	105%			100%
18	Hospitalization: C-section			104%	89%			100%
Number of Facilities Reporting		25	66	16	6	6	4	119
Number of Services with Prices:								
1. Less Than MOH-wide Avg.		0	7	6	8	12	12	
2. Greater Than MOH-wide Avg.		0	2	12	9	1	1	
3. Equal to the MOH-wide Avg.		1	2	0	1	0	0	
Unweighted Average of the Mean Price Relative to the MOH-wide Average Price:		100%	85%	109%	116%	74%	66%	

Graph 5: Facility Types' Average of Their Mean Service Prices Relative to the MOH-wide Average Service Price



Graph 6 presents information using a second method of comparing the average prices of specific types of facilities to the MOH all facilities' average price. The method just described analyzes the average of the average prices (i.e., the mean of the mean prices). As such, if there are one or a few services with extremely high or low prices they are likely to have a disproportionate influence on the general findings, by acting to distort the average, pushing it much higher or lower than it would otherwise be. The best example of this is the non-psychiatric, national hospitals' "dental: extraction" (service ranking #5), which has an average price that is 235 percent the MOH average price. The magnitude of price differentials is a pertinent concern in assessing user fee systems. However, it is not the only one. It is important to eliminate the undue influence of extreme outliers—that is, especially high prices—so that a single price of potentially a little provided service does not result in our characterizing an entire fee structure as having an uncommonly high average level. In short, average relative price levels, alone, doe not provide adequate information for assessing relative fee structures.

A second method was developed for comparing the average prices across facilities is one that is relatively insulated from extreme values. This measure consists of identifying, for each type of facility, the percent of the services with fees that have average levels less than those of the MOH facility-wide average. As Graph 6 shows, the national hospitals have, by far, the largest proportion of their services for which fees are charged priced at levels that are less than the MOH-wide average fee. Indeed, more than nine in ten of the national hospitals' services have average prices that are less than those of the MOH-wide average price. In contrast, only one-third of the services with specific fees that are provided in the area hospitals are priced, on average, at less than the MOH-wide average. By this second measure, the area hospitals have the highest average prices for care of any of the MOH facility types.

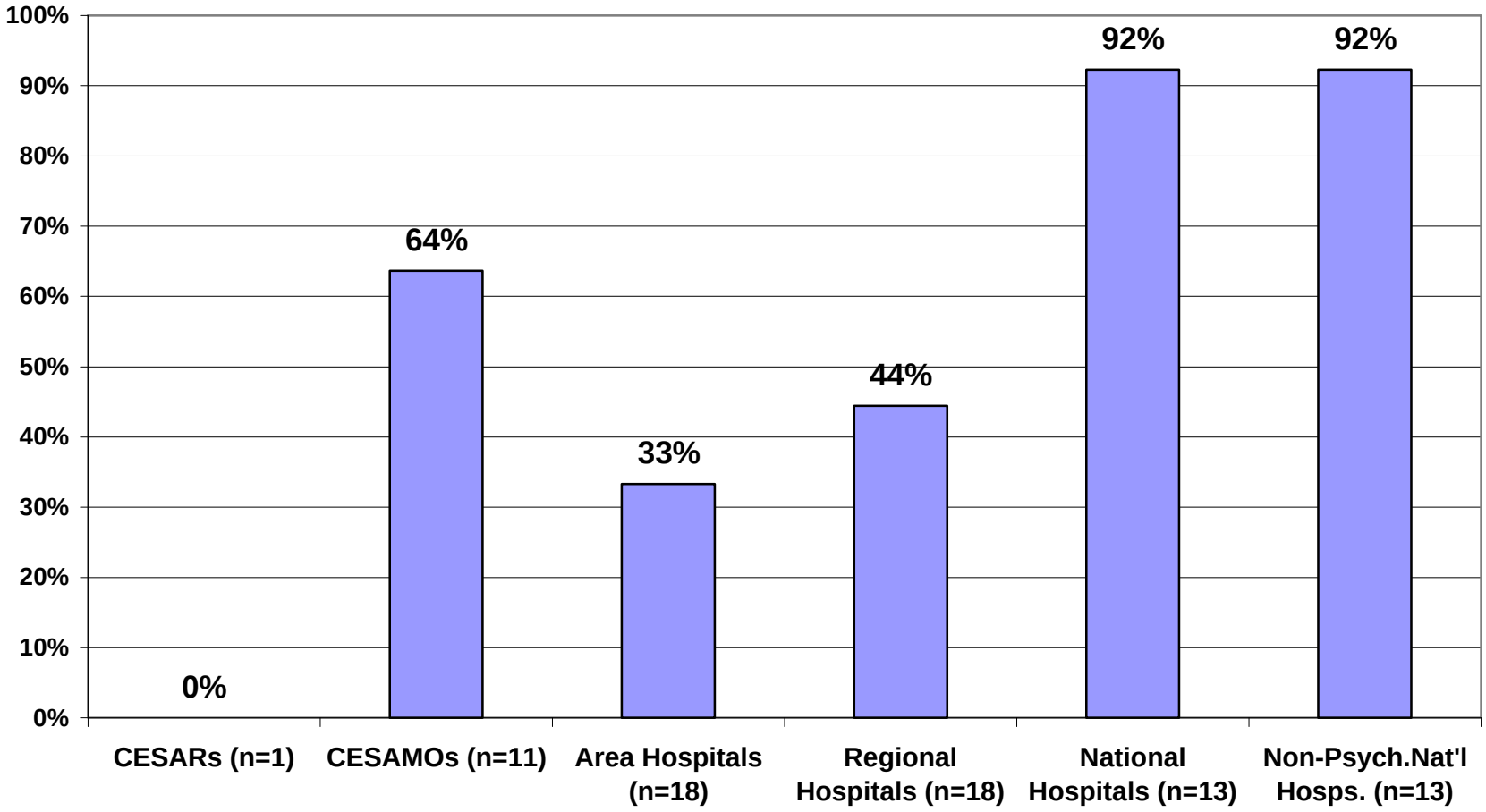
Recall, as measured by the application of the first relative measure— the average of a particular type of facility's mean service prices relative to the MOH-wide average price—the regional hospitals had the highest priced care. Closer examination of the regional hospitals' mean prices, however, (refer back to Table 19) reveals that just two services—two outliers—are primarily responsible for making them higher priced, on average, than the area hospitals. If the regional hospitals' prices for a "birth," (service ranking #13) and a "dentistry: provisional filling" (service ranking #12) are dropped from the calculation, the regional offices average falls to 93 percent, less than the area hospitals' average. Moreover, if the two most extreme values of the area hospitals are excluded, the area hospital average only falls to 105 percent.

In conclusion, considering only the level of established institutional user fees in the sample of facilities surveyed, while only taking into account the service mix in a very crude manner and without taking into account the patient mix (i.e., the number of each type of service provided), the type of MOH facility that has the highest average prices are the area hospitals, followed by the regional hospitals. The national hospitals and a sub-set of the national hospitals, the non-psychiatric facilities, on average have the lowest average price, even lower than CESAMOs or CESARs.

4.6.3 Price Variations 2 -- Within Each Facility Type Category

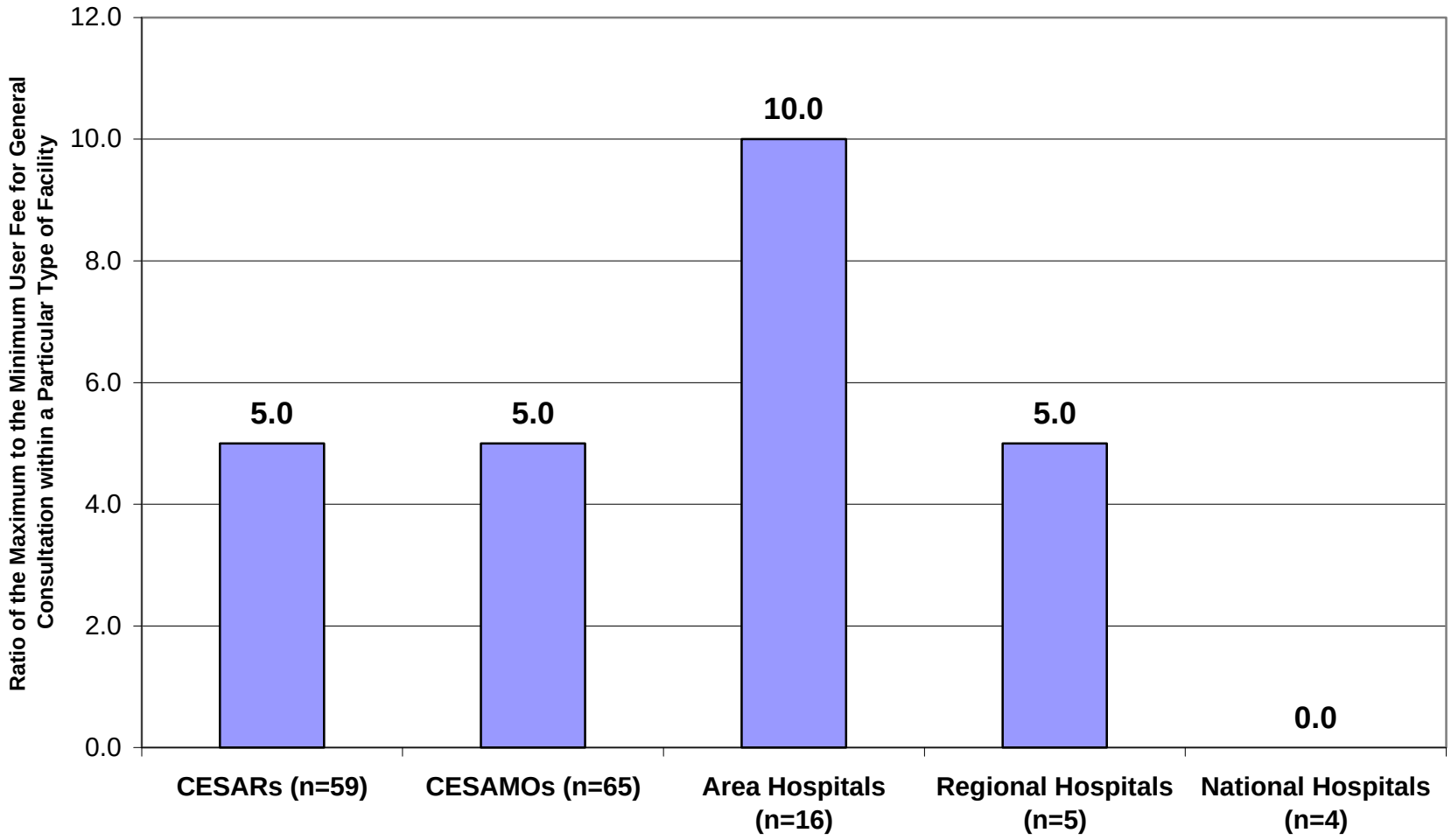
The price of a particular type of service varies significantly across facilities of the same type, as well. Graph 7 presents the intra-facility type variation in the price of a general consultation, measuring variation as the ratio of the maximum to the minimum price. In three of the five types of MOH facilities the price of a general consultation varies by a factor of five. The greatest within-facility type variation is found in the area hospitals, where the price of a general consultation varies

Graph 6
Percent of Services with Average Prices that are Less than the MOH-wide Average Price



Graph 7: Variation in the Price of a General Consultation Within Facility Types

("n" Indicates the Number of Facilities Compared Within Each Type of Facility)



ten-fold, and in the four non-psychiatric, national hospitals, where it is a uniform one lempira (i.e., where there is no variation).

A set of comparisons of the institutional prices within each facility type was developed. In the case of CESAMOs, regional and national hospitals, comparisons were made of all services for which there are at least two facilities that charge for a specific service. The more highly differentiated fee structure of the area hospitals prompted looking at only those services for which there were distinct prices charged by at least four facilities in order to keep the number of comparisons more manageable. Applying these criteria produced 12 CESAMO services, 53 area hospital services, 27 regional hospital services and 12 non-psychiatric, national hospital services that served as the bases for comparing price variation within a given type of facility. For each type of facility the maximum price was divided by the minimum price to provide a measure price variation. A simple (unweighted) average of this measure of variation was computed for all of the comparison services for each type of facility. These summary measures are presented in Graph 8. (Annex C contains a series of tables presenting a number of descriptive statistics on each of the services for each type of facility.) As Graph 8 shows, price variations are greatest in CESAMOs, where they vary on average by a factor of 4.3. In other words, for the 12 services analyzed, on average the prices charged by CESAMOs vary by a factor of 4.3. If, for instance, the minimum fee charged for a particular service is three lempiras, that same type of service, on average, will have a price of 12.9 lempira in another CESAMO. The facilities with the least amount of price variation are the four non-psychiatric, national hospitals, while regional hospitals' services have only slightly greater price variation.

4.7 Types of Services Provided Free-of-Charge

The Regulation and Manual for Recovered Funds states (page 11) that the following services will be provided free-of-charge:

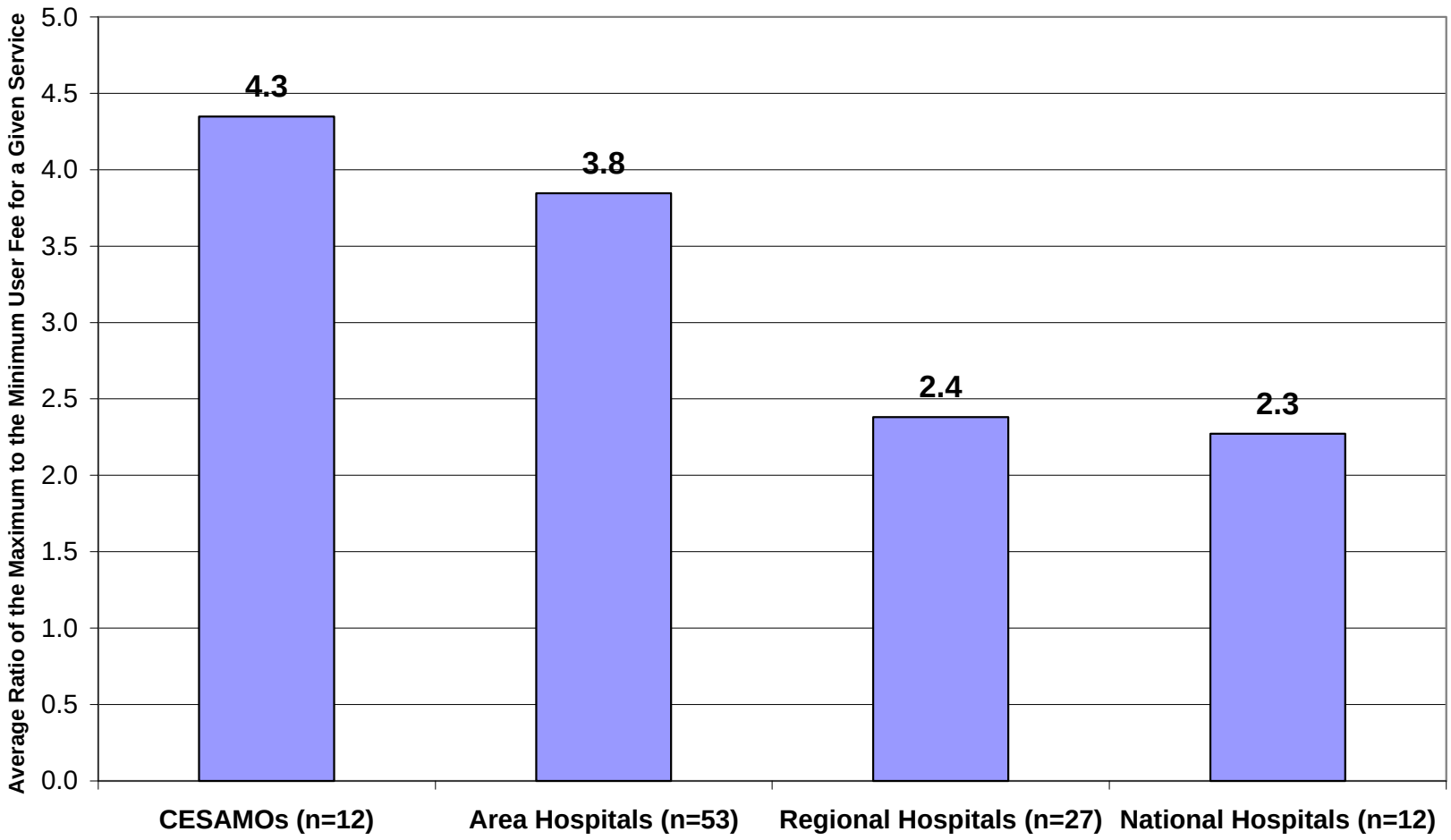
- prenatal care,
- growth and development,
- immunizations,
- family planning,
- sexually transmitted diseases, and
- tuberculosis.

Graph 9 shows the extent to which this policy is enacted. While the general level of adherence to the policy is high, none of the MOH's six priority services is universally provided free of institutional user fees. The most widespread free service practice involves vaccinations. At the other extreme, fees are levied for more than one-quarter of sexually transmitted diseases. While there can be no doubt but that user fees discourage utilization, there is no data on Hondurans' sensitivity to prices with which to quantitatively assess the impact of these fees.

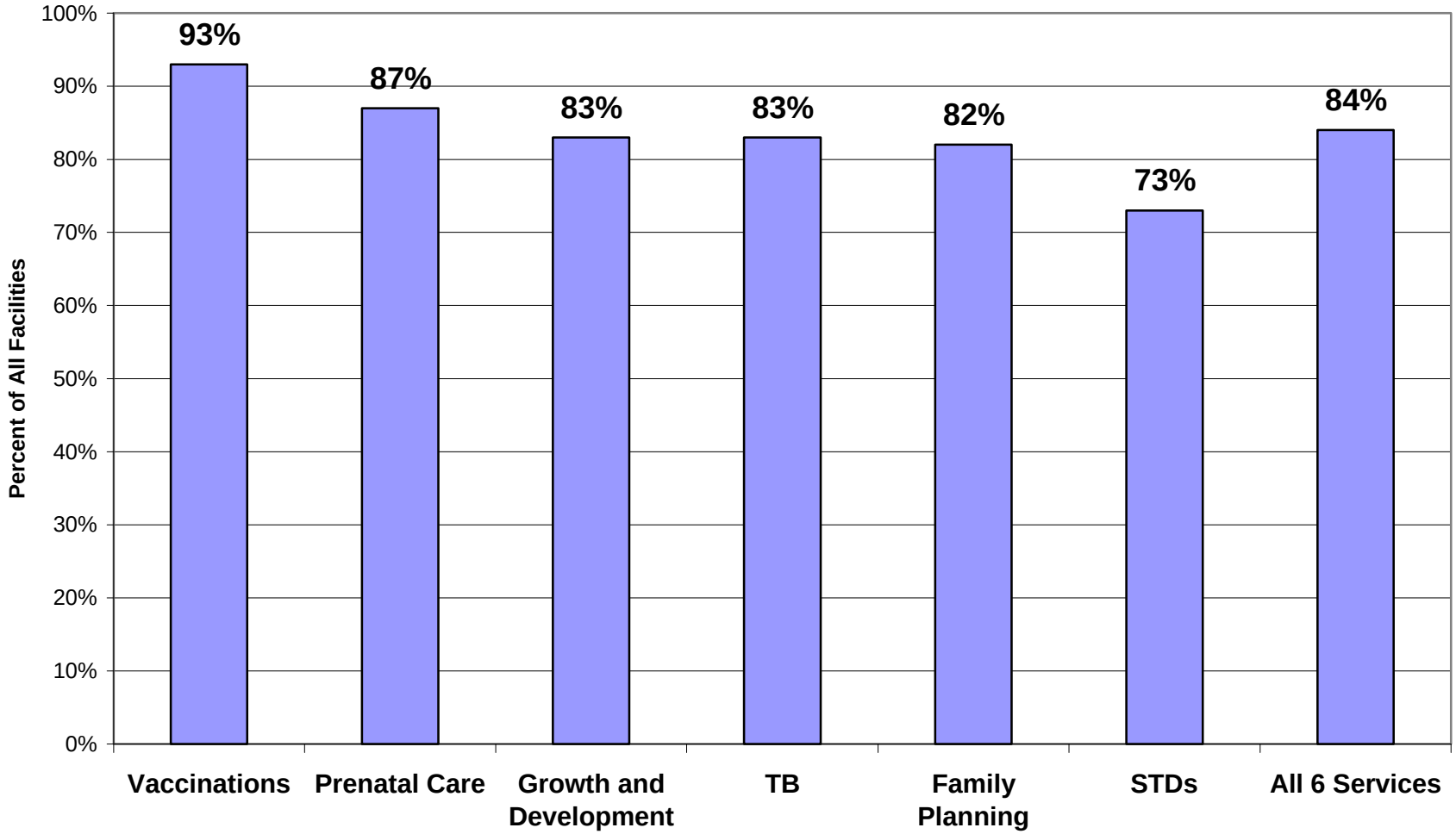
As may be seen in Graph 10, only seven percent of the surveyed facilities with institutional user fee systems provide all six of the priority services free-of-charge, and the degree of compliance varies substantially across the five different types of facilities. CESAR's were, by far, more likely to

Graph 8: Institutional User Fee Variation Within Facility Types

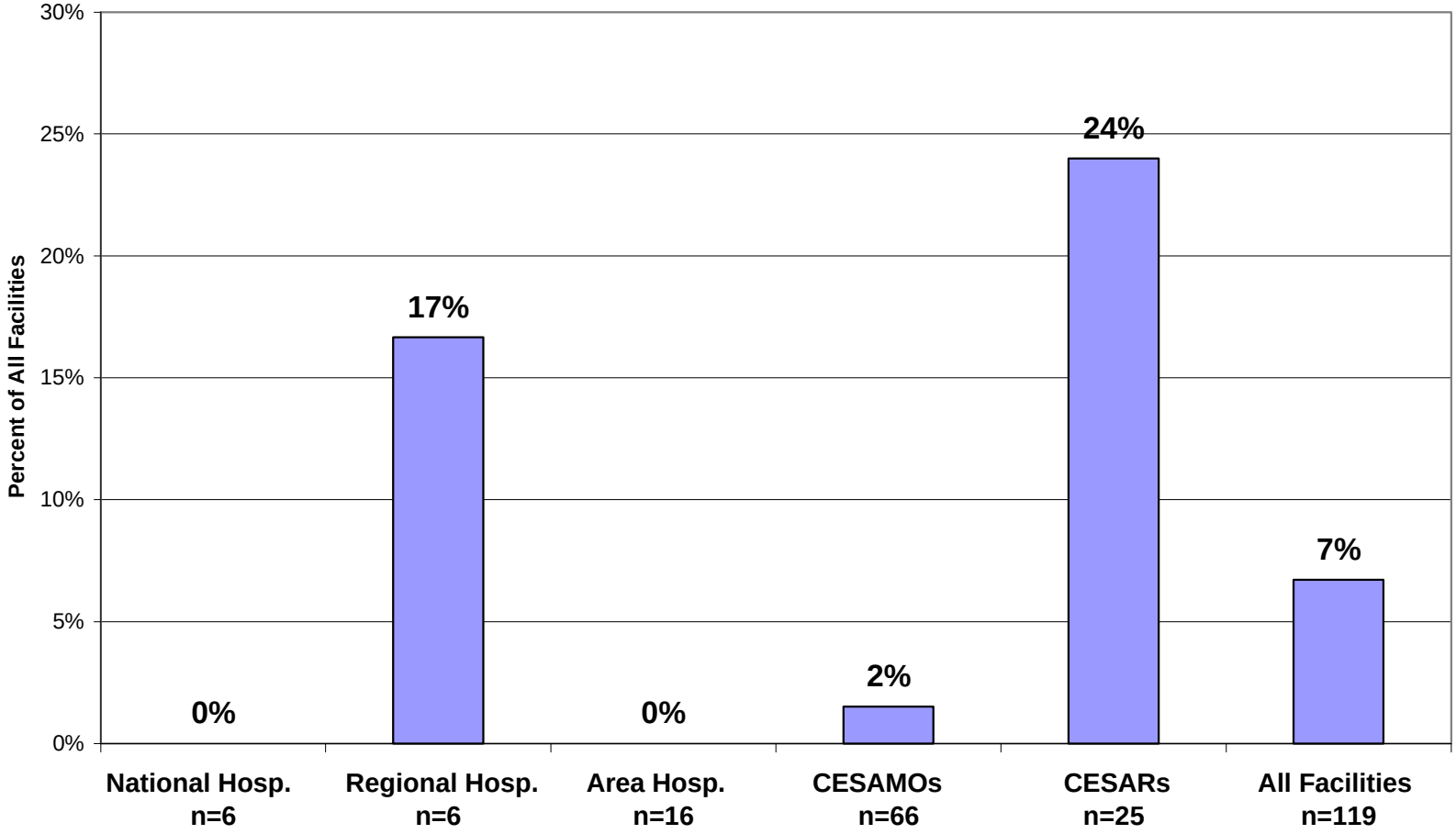
("n" Indicates the Number of Services Compared Within Each Type of Facility)



Graph 9: Percent of Facilities Adhering to the RMFR Mandate to Provide Priority Services Free of Institutional User Fees



Graph 10: Percent of Surveyed Facilities that Provide All Six Services MOH Priority Services Free of Institutional User Fee Charges



fully adhere to this MOH policy than any other type of facility. The regional hospitals' 17 percent share ranked second, while there was near total non-universal compliance in each of the other three facility types.

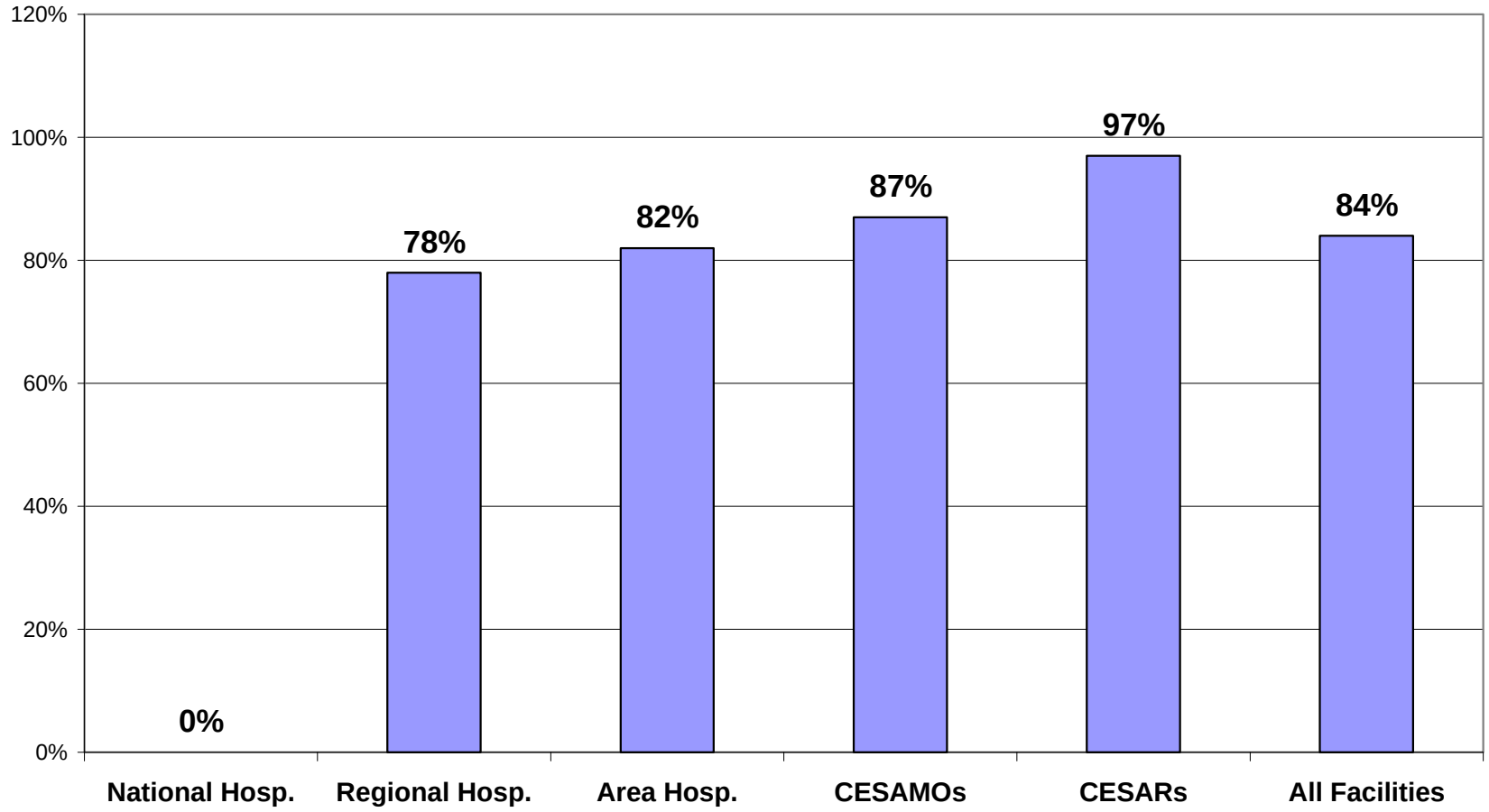
As Graph 11 shows, 97 percent of the 6 services provided in the 25 CESARs with institutional systems were provided free. Moreover, when the five CESARS that have mixed systems are excluded from the analysis, the remaining 20 CESARs have 100 percent compliance with the free service mandate. The average facility provides about five of the six services (84 percent) free. As is readily evident in the graph, the degree of adherence to the free care mandated is inversely related to the position of the facility type in the MOH pyramidal referral network. None of the national hospitals provide any of the priority services free-of-charge. The regional hospitals have the next lowest proportion, followed by the area hospitals, the CESAMOs and finally the in near complete compliance, CESARs.

Graph 12 compares the proportion of free care provided by institutional and community user fee systems. As noted earlier, the RMRF does not establish requirements or make recommendations about either the structure or the level of fees in community user fee systems. In particular, it does not stipulate that these systems must provide these priority services, or any other services, free-of-charge. This observation, coupled with the recognition that local people have more complete control and discretion over the use of a community system's revenues, would lead one to expect that the community systems' would be more likely to charge for these services. That, however, is not the case. Although the differences in the practices of the two user fee systems are not marked, as may be seen in Graph 12, for five of the six types of priority services the proportion of community user fee systems that provide the service free-of-charge exceeds that of the institutional user fee systems. Nor are these differences attributable only to the different facility mix of community and institutional systems. While community systems are much more prevalent in CESARs and CESARs are the best institutional performer in terms of providing the priority services free-of-charge. Table 20 shows that only one of the five CESAMOs with a community system is not in complete compliance with the free service mandate. (It does not provide sexually transmitted diseases free.)

It is noteworthy that the community systems demonstrate a high level of concurrence with the intent of the MOH mandate by providing preferential treatment for these services, even though they are not required to do so. This would seem to allay at least some of the concern that the community systems, being shaped by local needs and priorities, may operate in a manner that is less than entirely consistent with national public health policy goals. Indeed, ironically, it must be concluded here that they, in fact, adhere more closely to MOH policy than the more MOH-directed, -structured and -controlled institutional systems. This line of inquiry will continue to be investigated throughout the remainder of this study, as this observation cannot be construed as providing anything approaching a definitive conclusion about this important issue. There are a number of other dimensions along which and will be examined below. Distilling a better, more holistic institutional assessment of these systems is essential to better understanding local priorities (as reflected in local practices) and to becoming better informed about how to reform the existing user fee systems, and doing so in a way that maximizes local control, without unduly compromising public health goals, equity, efficiency or the integrity of user fee systems.

Respondents were queried about all of the different kinds of services that they provide free-of-charge or at reduced rates, not only the MOH's six priority services. As already noted, only 7 percent of the interviewed facilities with institutional user fee systems provide all six of the MOH priority services free-of-charge. Nevertheless, the average number of different types of services provided, on average, free-of-charge by regional hospitals, area hospitals, CESAMOs and CESARs is about six.

Graph 11: Adherence to MOH Policy of Mandated Free Services-- Percent of Facilities Providing Each of the Mandated Services Free of Institutional User Fees Charges



Graph 12: Percent of Services the MOH Mandates to be Free that Surveyed Facilities Report They Routinely Provide Free-of-Charge, by Type of User Fee System

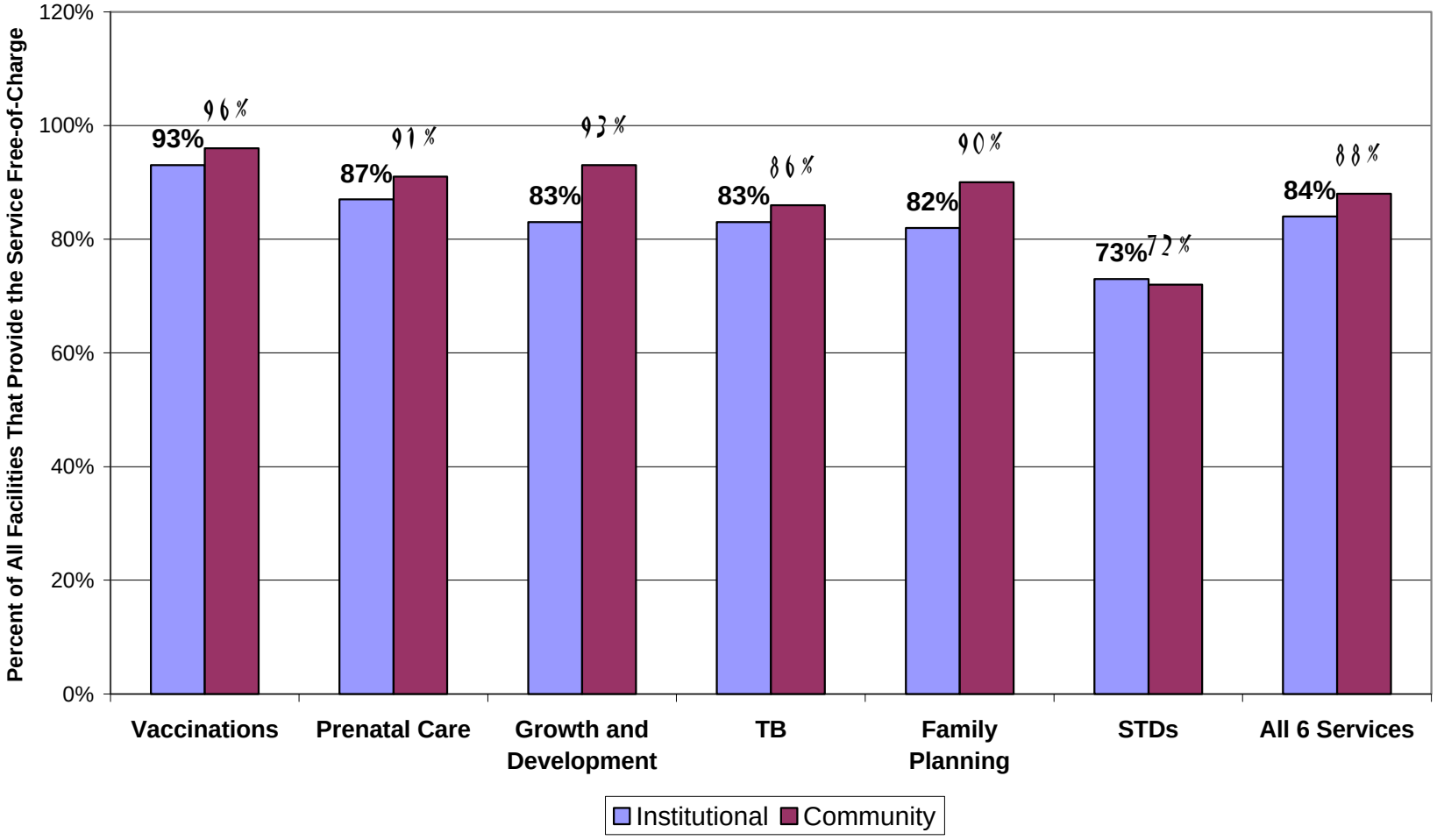


Table 20
Types of Services Provided Free-of-Charge
by Type of User Fee System and Type of Facility

Number and Percent of Each Type of Facility Providing Free Care

Type of Service	*Community User Fee Systems*			*Mixed User Fee Systems*			*Institutional User Fee Systems*			*All User Fee Systems*		
	CESAMOs	**CESARs**	**Both**	**CESAMOs**	**CESARs**	**Both**	**CESAMOs**	**CESARs**	**Both**	**CESAMOs**	**CESARs**	**Both**
1 Vaccinations	5 100%	59 97%	64 97%	9 100%	5 100%	14 100%	56 100%	20 100%	76 100%	70 100%	84 98%	154 99%
2 Prenatal Care Consultations	5 100%	56 92%	61 92%	8 89%	5 100%	13 93%	53 95%	20 100%	73 96%	66 94%	81 94%	147 94%
3 Growth and Development Visits	5 100%	56 92%	61 92%	9 100%	5 100%	14 100%	50 89%	20 100%	70 92%	64 91%	81 94%	145 93%
4 Tuberculosis	5 100%	53 87%	58 88%	8 89%	4 80%	12 86%	50 89%	20 100%	70 92%	63 90%	77 90%	140 90%
5 Family Planning	5 100%	55 90%	60 91%	8 89%	5 100%	13 93%	49 88%	20 100%	69 91%	62 89%	80 93%	142 91%
6 Sexually Transmitted Diseases	4 80%	44 72%	48 73%	7 78%	3 60%	10 71%	38 68%	20 100%	58 76%	49 70%	67 78%	116 74%
7 Postpartum Exam	0 0%	14 23%	14 21%	3 33%	2 40%	5 36%	6 11%	4 20%	10 13%	9 13%	20 23%	29 19%
8 Injections	0 0%	3 5%	3 5%	0 0%	0 0%	0 0%	10 18%	3 15%	13 17%	10 14%	6 7%	16 10%
9 Treatments	0 0%	3 5%	3 5%	0 0%	0 0%	0 0%	5 9%	1 5%	6 8%	5 7%	4 5%	9 6%
10 Diarrheal disease treatment	0 0%	3 5%	3 5%	0 0%	0 0%	0 0%	1 2%	0 0%	1 1%	1 1%	3 3%	4 3%
11 Cytology	1 20%	1 2%	2 3%	1 11%	0 0%	1 7%	0 0%	0 0%	0 0%	2 3%	1 1%	3 2%
12 Others mentioned at most twice	1 20%	6 10%	7 11%	1 11%	0 0%	1 7%	5 9%	0 0%	5 7%	7 10%	6 7%	13 8%
Total Number of Free Services:	31	350	381	54	29	83	322	128	450	407	507	914
Avg. No. of Free Services Per UPS	6.2	5.7	5.8	6.0	5.8	5.9	5.8	6.4	5.9	5.8	5.9	5.9
Total Number of Facilities	5	61	66	9	5	14	56	20	76	70	86	156

(See Graph 13.) This is due to the fact that they all have policies whereby they provide other types of services free-of-charge, either on their own authority or with that of their respective Regional Offices.

Table 21 presents a listing of the types of services provided free of institutional user fee charges and their prevalence and relative frequencies by type of facility. The sum of all of the non-MOH official priority free services constitutes 10 percent of the total free services provided by the 119 surveyed facilities with institutional UFSs. That percentage, however, varies systematically by type of facility. Those facilities that are most likely to provide the MOH-mandated priority services free-of-charge, provide the smallest proportion of other services free-of-charge, and vice versa. Graph 14 presents the proportion of all free services that are other than the priority services. The extreme performances are those of (1) the national hospitals, which do not provide any of the priority services free-of-charge, but do provide several services without charge, and, at the other extreme, (2) the CESARs, whose providing additional services (more than those mandated to be free) constitutes only 6 percent of their total free services.

An estimate of the financial impact of adhering to or not adhering to the free care mandate was developed. It was assumed that the revenues foregone owing to the free provision of priority services are equal to the quantity of each of those services actually provided in 1999 multiplied by the general consultation fee. In facilities that do not provide these services free, this same procedure provides an estimate of how much the facility financially gained by not enacting MOH policy. These estimates are provided in Table 22. The Table presents a variety of financial data related to charges and non-charges for these MOH mandated services. The table contains the weighted sample results, thus providing nation-wide estimates. Since the RMRF requires only that institutional user fee systems provide these services free of charge, the table provides information only about institutional user fee systems and the financial implications of compliance or non-compliance with the mandated.

Row (2) in Table 22 contains the total number of visits of each of the priority services. The infectious diseases column contains the sum of tuberculosis and sexually transmitted diseases treatment visits. In 1999, there were nearly 2.4 million of these four types of consultations, 37 percent of the total consultations provided by the MOH. Clearly, the mandating these services to be free-of-charge has an important constraining effect on the institutional user fee system's revenue generating capacity. This is not to suggest that these services should be charged for. On the contrary, these are services are probably cost-effective in the long term, and the infectious diseases provide considerable positive externalities (that is, benefits to third party persons) which suggests they will be under-consumed and should be provided free to encourage their consumption in more socially desirable quantities. The purpose of this exercise is simply to demonstrate the financial implications of the effect of this policy of free care.

Returning to Table 22, row (3) contains the number that were actually provided free of institutional user fee charges. They constitute the equivalent of 28 percent of all consultations provided by the MOH in 1999. Row (4) contains the percent of all visits (row 2) that the free care actually provided (row 3) represents. The level of compliance is similar for three of the four types of visits, with the treatment of infectious diseases lagging. Compliance with the mandate is best for child growth and development consultations, at 77 percent. The numerical dominance of growth and development visits, accounting for 72 percent of the four categories' total, means the overall rate of compliance with the mandate to provide these services free-o-charge is higher than the rate of the other three service categories.

Row 5 shows the revenues that are foregone as a result of providing these services free-of-charge, assuming the fee charged would be the general consultation fee reported in the survey (which implicitly assumes that demand remain constant—i.e., not fall—if a price were charged for these services). The foregone revenues total 2.1 million lempiras.

Graph 13: Average Number of Types of Services that are Routinely Provided Free of Institutional User Fee Charges

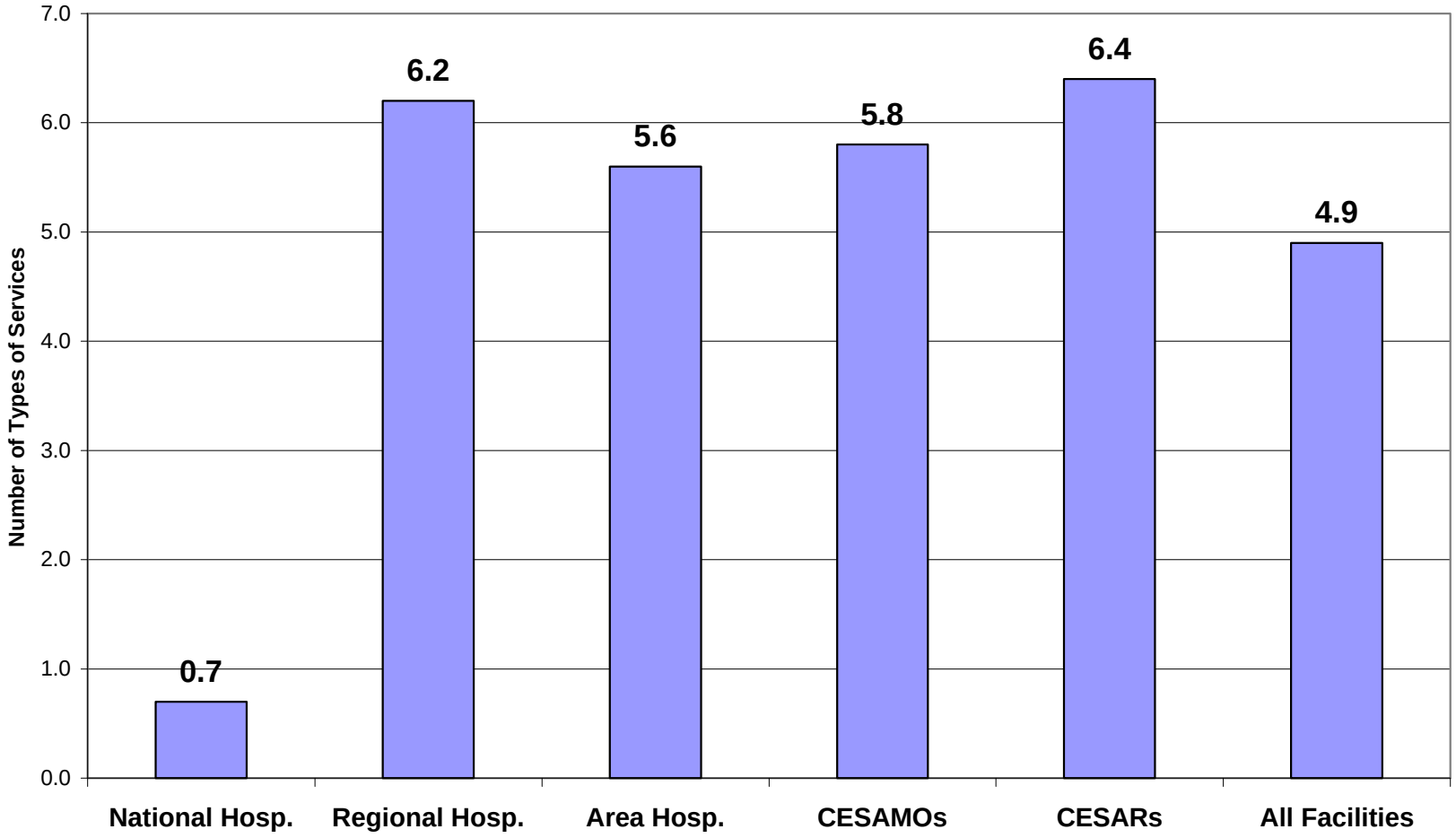


Table 21
Types of Services Provided Free of Institutional User Fee System Charges
Number and Percent of Each Type of Facility Providing the Service Free-of-Charge

Type of Service	*Type of Hospitals* National	Regional	Area	All Hospitals	CESAMOs	CESARs	All UPSs
1 Vaccinations	0	6	15	21	56	20	97
	0%	100%	94%	75%	100%	100%	82%
2 Prenatal Care Consultations	0	4	14	18	53	20	91
	0%	67%	88%	64%	95%	100%	76%
3 Growth and Development Visits	0	4	11	15	50	20	85
	0%	67%	69%	54%	89%	100%	71%
4 Tuberculosis	0	4	13	17	50	20	87
	0%	67%	81%	61%	89%	100%	73%
5 Family Planning	0	5	12	17	49	20	86
	0%	83%	75%	61%	88%	100%	72%
6 Sexually Transmitted Diseases	0	5	14	19	38	20	77
	0%	83%	88%	68%	68%	100%	65%
7 Postpartum Exam	0	0	1	1	6	4	11
	0%	0%	6%	4%	11%	20%	9%
8 Injections	1	1	0	2	10	3	15
	17%	17%	0%	7%	18%	15%	13%
9 Treatments	0	1	0	1	5	1	7
	0%	17%	0%	4%	9%	5%	6%
10 Cytology	0	1	0	1	0	0	1
	0%	17%	0%	4%	0%	0%	1%
11 Nebulizations	0	1	0	1	1	0	2
	0%	17%	0%	4%	2%	0%	2%
12 Malaria test	0	0	1	1	0	0	1
	0%	0%	6%	4%	0%	0%	1%
13 Diarrheal disease treatment	0	0	0	0	1	0	3
	0%	0%	0%	0%	2%	0%	3%
14 Others mentioned at most twice	3	5	8	16	4	0	23
	50%	83%	50%	57%	7%	0%	19%
Total Number of Free Services:	4	37	89	130	322	128	583
Avg. No. of Free Services Per UPS	0.7	6.2	5.6	4.6	5.8	6.4	4.9
Total Number of Facilities	6	6	16	28	56	20	119

Graph 14: The Proportion of All Services Provided Free of Institutional User Fees that are Other Than the MOH-Mandated Six Free Services

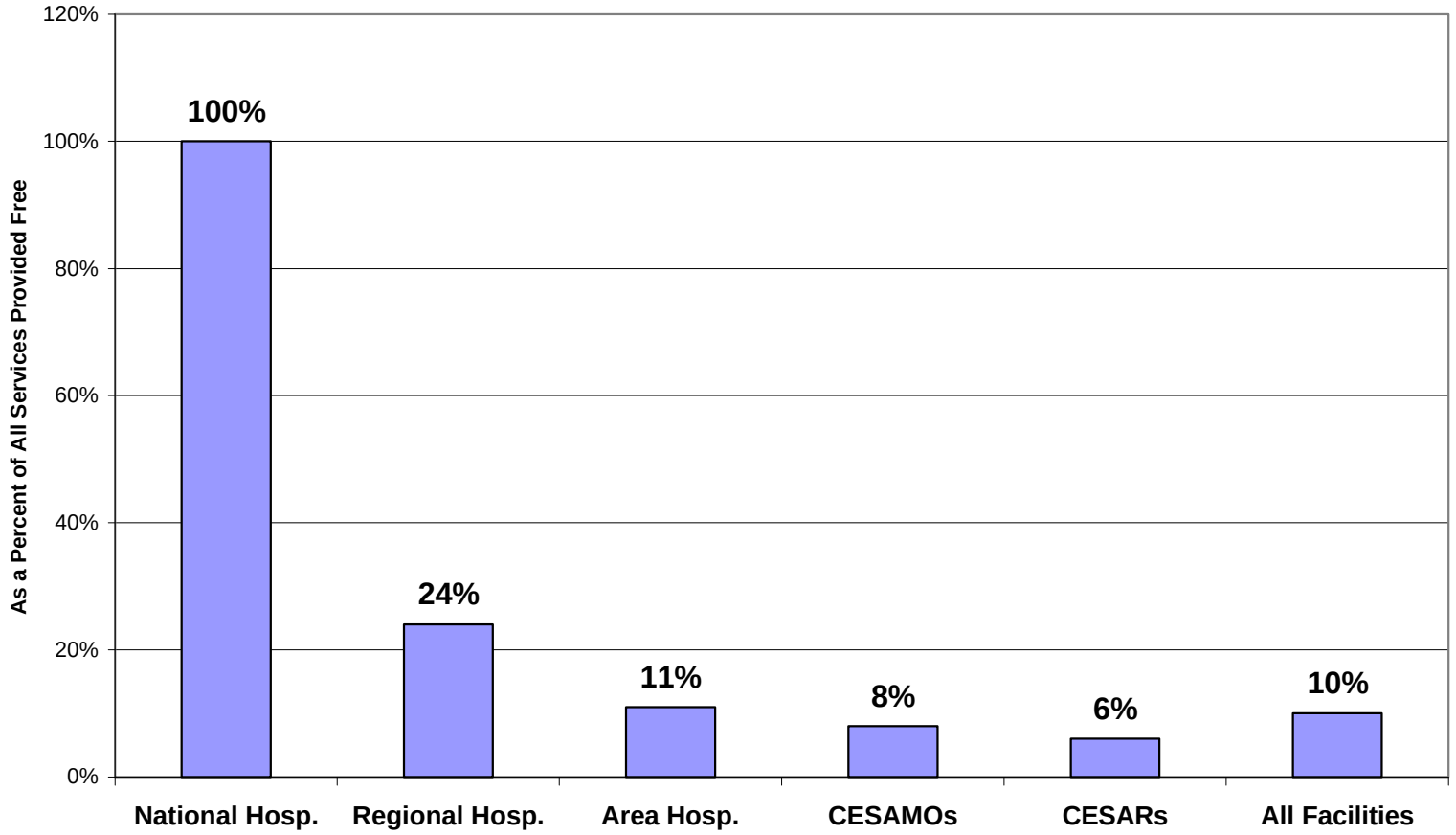


Table 22
Revenues and Revenue Implications of the MOH Mandate to Provide Priority Services Free of Institutional User Fee Charges
An Assessment of 1999 in the Surveyed Facilities
Weighted Sample Estimates

	Prenatal Care	Growth & Development	Family Planning	Infectious Diseases	Sum of these Four MOH Priority Services	All Consultations	These 4 as a Percent of All
(1) Number of Facilities (unweighted)	184	184	184	185	185	184	184
(2) Total No. of Visits	491,389	1,704,777	181,425	6,400	2,383,991	6,414,519	37%
(3) Number Provided Free-of-Charge	369,382	1,307,764	130,376	3,703	1,811,225		28%
(4) Percent Provided Free-of-Charge	75%	77%	72%	58%	76%		
(5) Foregone Revenues Due to Providing Free-of-Charge (In Lempiras)	492,531	1,463,149	157,014	6,890	2,119,584		
(6) Maximum Potential Revenues if Fee Were Charged for All Four and Demand Did Not Decrease	568,590	1,696,027	186,458	8,633	2,459,708		
(7) Revenues Collected on These 4 Services in Violation of the MOH Mandate to Provide Them Free-of-Charge:	76,059	232,878	29,444	1,743	340,124		

As Row 7 shows, institutional user fee system revenues estimated at about 340,000 lempiras, are collected on these services in violation of the RMRF. Row 6 contains the maximum potential that would be collected on these services if the general consultation fee were charged for them and demand remained constant. Although 24 percent of the services are charged for, the revenues generated are equal to only 14 percent of what would be generated if all facilities charged for all of these services. It may be inferred that the facilities that charge for these services have lower than average general consultation charges.

4.7.1 Potential Revenue Implications of the Changing MOH Service Mix

The total number of consultations, and the total number of each of these four free mandated types of services by the entire MOH annually from 1996 through 1999 is presented in Table 23. The total number of mandated free services (column F) increased by 21 percent over this period. At the same time, the number of potentially paid-for consultations (column G) increased by slightly more, 22 percent. With total service delivery of the Ministry increasing, both the number of services mandated to be provided free and those that can potentially generate more revenue have both been increasing. Thus the potential revenue base of the Ministry is expanding in an absolute sense; more services are being provided that can be charged for. However, with free-of-charge services growing at virtually the same rate as ***potentially*** revenue generating services, it is highly likely that in relative terms, actual revenue generating services are probably falling; i.e., the proportion of care that charges can be levied and collected on is probably falling because not all persons who receive services that they can be charged for, are in fact charged for them. How much it may be eroding depends on the proportion of persons who do not pay for care because (1) they are regarded as medical indigents, (2) because the RMRF or facility-policy grants them a categorical exemption (e.g., they are active community health personnel) or (3) because they receive their care from a facility that does not have a user fee system. To the extent that facilities use their user fee systems to cover financing gaps, this trend will put increasing pressure on facilities to increase their cost recovery practices by charging more for care, by exonerating fewer people from paying for care or by charging for services that are supposed to be provided free.

If this trend in service mix is maintained, it means that the effectiveness of the user fee system as measured by its cost recovery performance (measured as user fee revenues as a proportion of total costs/expenditures) will be eroded. Is that acceptable? If not, the options are: (1) either to reduce or eliminate the number and type of free services, (2) exempt fewer persons from payment (either categorically or for reason of medical indigency), (3) increase average user fees, or (4) some combination of these alternatives.

We are unable to estimate the revenue losses due to providing services other-than the MOH priority services free-of-charge, however, because there is no information on the number of persons who are exempted from payment for these other services. The MOH information system does not explicitly identify these types of services (reflecting the fact that they are not priorities of the MOH and thus are not differentiated in the information system).

4.8 Categories of Patients/Persons Who Receive Free Care

The discussion in this section is limited to policies. No quantitative information was available about the frequency with which these policies are exercised; i.e., the frequency of the practice of providing free

Table 23
MOH Outpatient Health Care Service Provision, 1996-1999
Total Consultations, Potentially Paid for Care and Care Designated by the MOH to be Provided Free-of-Charge

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)
		Care that the MOH Mandates are to be Provided Free-of-Charge					Total Con-	Free Care
	Total Consultations	Prenatal Care	Family Planning	Growth and Development	Specified Transmisible Diseases*	All Care Identified As Free	sultations Potentially Paid For	Services as a % of Total Visits
1999	6,628,759	498,494	181,869	1,652,352	7,521	2,340,236	4,288,523	35%
Number of Facilities	1,134	1,134	1,134	1,134	1,134	1,134	1,134	1,134
1998	6,653,663	542,359	181,150	1,717,378	6,188	2,447,075	4,206,588	37%
Number of Facilities	1,096	1,096	1,096	1,096	1,096	1,096	1,096	1,096
1997	5,574,017	445,874	144,807	1,457,643	6,288	2,054,612	3,519,405	37%
Number of Facilities	1,040	1,040	1,040	1,040	1,040	1,040	1,040	1,040
1996	5,449,719	430,766	125,500	1,374,753	7,493	1,938,512	3,511,207	36%
Number of Facilities	960	960	960	960	960	960	960	960

care to different categories of persons.[12] Hence, there is only partial information about the significance of this practice—we know the frequency with which facilities grant these categorical exemptions as a matter of policy, but we don't know how often they do so.

The Regulation and Manual for Recovered Funds states that all active community health personnel ("miembros el personal comunitario activo," page 11) are to be exempted from paying institutional use fees. This ambivalent clause is interpreted different ways, but generally has come to be defined to include all MOH employees and their immediate families. The Manual also states that persons who it is determined do not have the capacity to pay (as determined by a social worker or other facility representative) are to be exempted from payment, as well.

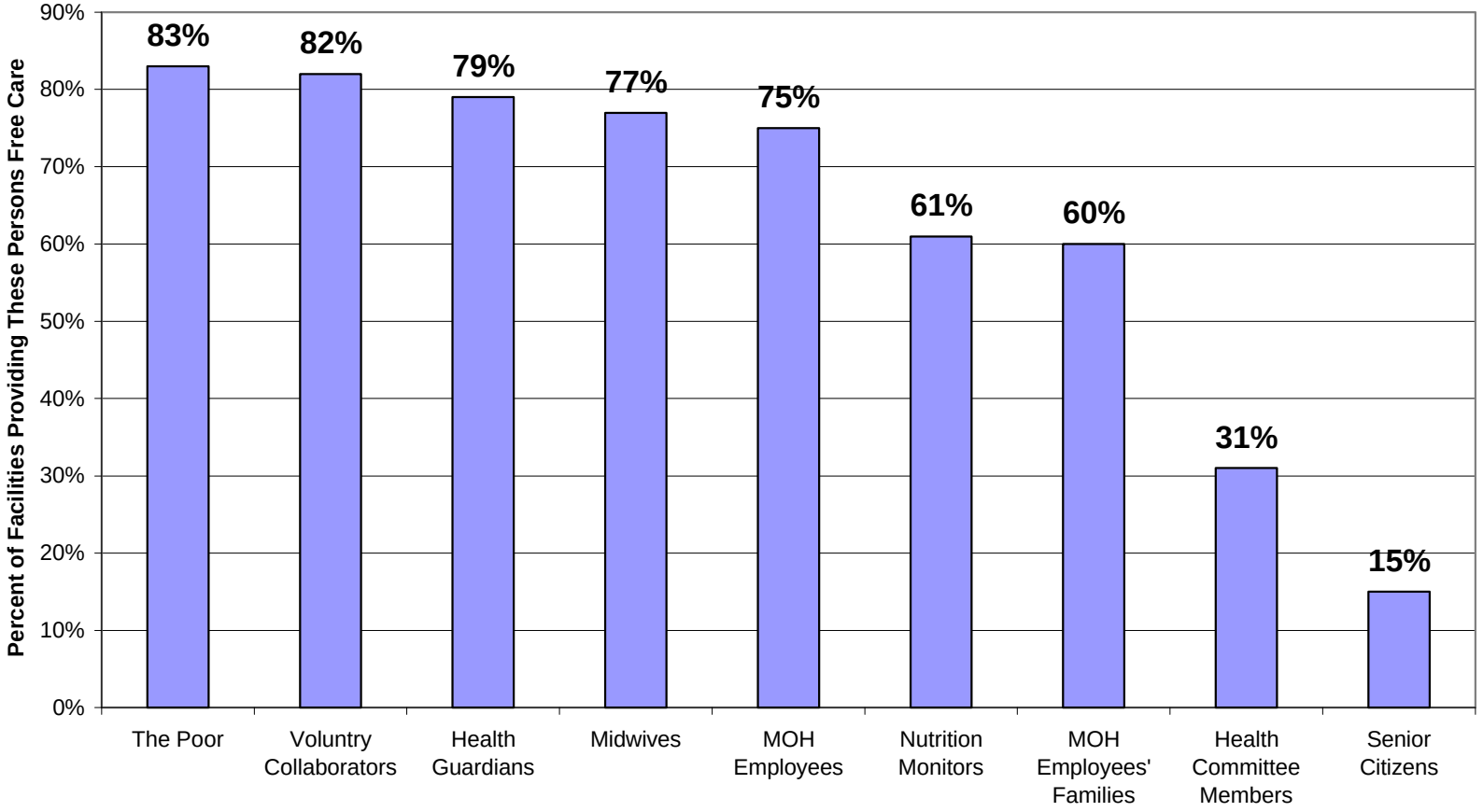
The PHR survey asked interviewees what groups of persons were not required to pay, or who were required to make only partial payment for care. In each facility for each class of persons who was identified as paying less than the customary user fee interviewees were asked the proportion of persons who were totally exempt from payment and the percentage who were paid only a portion of the regular fee. In the institutional user fee systems, partial payments constituted less than two percent of responses, and for community systems, they were less than one percent. Given the rarity of partial payment, the following discussion focuses only on the practice of providing care completely free of charges.

As may be seen in Graph 15, the most common category of persons provided care free of institutional user fee charges was "the poor," which was cited by 83 percent of the respondents. In other words, 17 percent of the surveyed facilities do not exonerate the poor from having to pay for care. Even though average fees are low, the frequency with which people persons regarded as poor, as a matter of local policy, are not exempted from payment was higher than anticipated. As Graph 16 shows, all of the hospitals report they provide free care to persons they regard as poor, as did most (91 percent) of the CESAMOs, and to a lesser extent, though still the vast majority (86 percent) the CESARs.

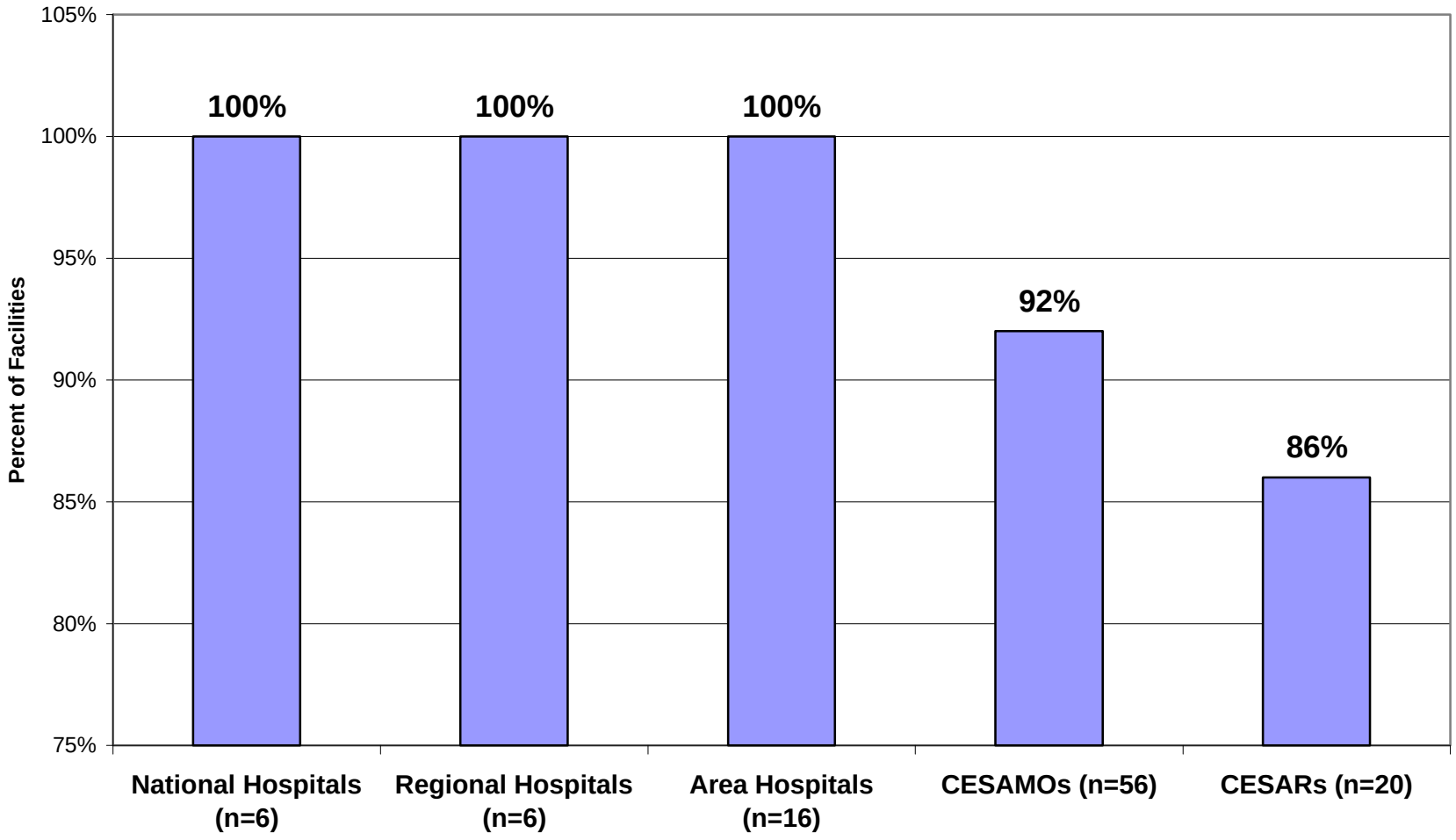
Further analysis by region, revealed that other than a few facilities in Copán, the only region in which the poor are not provided free care is Choluteca. Slightly less than half of the surveyed Choluteca facilities indicated they exempt the poor. Apparently the decision not to exonerate the poor is a local, facility-specific one, as Choluteca regional office staff reported that regional office policy recognizes the legitimacy of the practice. On average, Choluteca facilities are far less likely to provide free care to any specific categories of persons. As Graph 17 shows, while most regions provide free care to six categories of persons, Choluteca recognizes less than four.

[12] Initially, it was hoped that estimates of the frequency of the practice of exempted different types of persons from payment could be obtained in the interviews. However, during the pilot test of the instrument, interviewers reported that attempting to do so was cumbersome and time-consuming, and that they did not have much confidence in the information that was obtained. Accordingly, this approach was abandoned.

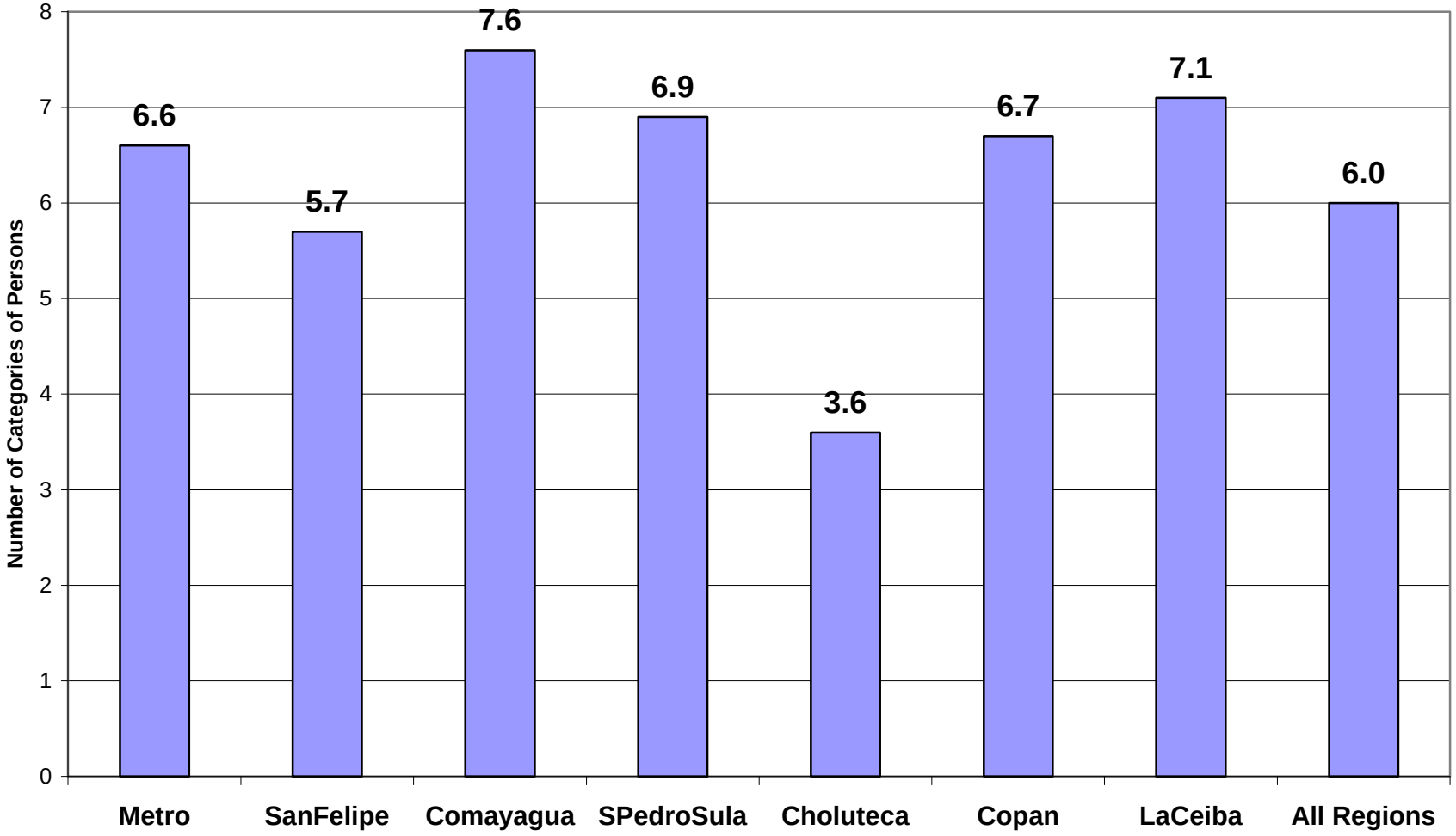
Graph 15: The Proportion of All MOH Facilities Providing Care Free of Institutional User Fees to Particular Categories of People



Graph 16: The Percent of Facilities That Report They Provide "The Poor" Care Free of Institutional User Fees



Graph 17: Average Number of Categories of People Who Are Provided Care Free of Institutional User Fee SystemFees, By Regional Office System



The specific mix of persons who are provided free care by regional office system is presented in Table 24.[13] The categories are rank ordered by the all regions' total number of facilities providing exemptions. The Comayagua region has the most consistent policy, all but one of the 10 categories takes on a value of 100 percent or zero percent; all of the facilities either provide free care to the category or they do not. San Felipe, too, has substantial amount of consistency, though there is data on only three facilities. In addition to extending free care to the smallest number of categories, Choluteca has the distinction of having the least consistent policy of exemptions

Beyond the provision of free care to the poor, most of the other specific categories of persons that that are provided free care meet the other free care qualification set forth in the RMRF; i.e., they are community health personnel. The exceptions are MOH employees' families, who 60 percent of the facilities reported they provide care free of charge and senior citizens, to whom 15 percent of facilities provide free care.

Table presents detailed data on the exemption practices of CESARs and CESAMOs disaggregated by type of user fee system. The mixed user fee systems have the most generous exemption policies; they have the highest percentage providing exemptions to a larger number of different types of persons (although, again, we have no information on the frequency with which this policy is actually practiced).

In CESARs, the community systems are more likely to provide exemptions, compared to the institutional systems. Even when the outlier region, Choluteca, is excluded from the analysis the CESARs' community systems, they remain more likely to have exemption policies and to exempt more types of persons from payment. This is again contrary to expectations. In light of the incentives in community vis-à-vis institutional systems, one would anticipate the community systems to be less generous, as is the case with in CESAMOs.

4.8.1 Identifying "the Poor"

Graph 18 shows the most common methods used to determine who is too poor to pay for care. The most common method, reported by 41 percent, was that "It is known who is poor." The next most frequently used method was to interview the patient. Surprisingly, nearly one-fifth of the systems are reported to conduct home visits. This method is the most involved and probably the most expensive in terms of staff time.

Table 25 reveals that there are systematic differences in the methods used by different types of facilities. The hospitals overwhelmingly (85 percent) use a socioeconomic assessment. Not surprisingly, in the more local type of facilities, the CESAMOs and CESARs, the predominant method cited is that the poor are known. This approach is used much more commonly in CESARs, 59 percent, whereas in CESAMOs home visits (28 percent) and patient interviews (24 percent) are frequently used as well.

[13] Juticalpa and Puerto Lempira are excluded because they each have only one observation, and cannot support making any generalizations about the region as a whole.

Table 24
Categories of Patients Who Receive Care Free of Institutional User Fee Charges
Number and Percent of Facilities Providing Services Free-of-Charge to Each Category by Region
Includes Only Area Hospitals, CESAMOs and CESARs
Includes Institutional and Mixed Systems

	Category of Patients	Metro-politana	San Felipe	Comayagua	San Pedro Sula	Choluteca	Copan	La Ceiba	Juticalpa	Puerto Lempira	All Regions
1	The Poor	5	10	12	19	14	14	14	3	1	**92**
		100%	100%	100%	100%	52%	93%	100%	75%	100%	86%
2	Voluntary Collaborators	5	10	12	18	15	15	14	2		**91**
		100%	100%	100%	95%	56%	100%	100%	50%	0%	85%
3	Health Guardians	4	9	12	18	14	14	14	3	1	**89**
		80%	90%	100%	95%	52%	93%	100%	75%	100%	83%
4	Midwives	4	7	12	18	13	15	14	3	1	**87**
		80%	70%	100%	95%	48%	100%	100%	75%	100%	81%
5	MOH employees	5	10	12	19	12	12	13	3	1	**87**
		100%	100%	100%	100%	44%	80%	93%	75%	100%	81%
6	Nutrition Monitors	3	5	12	16	12	9	7	3		**67**
		60%	50%	100%	84%	44%	60%	50%	75%	0%	63%
7	MOH employee's family member	3	5	12	15	5	10	11	3	1	**65**
		60%	50%	100%	79%	19%	67%	79%	75%	100%	61%
8	Health Committee Members	3	6	7	3	7	5	4	2		**37**
		60%	60%	58%	16%	26%	33%	29%	50%	0%	35%
9	Senior Citizens	1			2	6	2	3			**14**
		20%	0%	0%	11%	22%	13%	21%	0%	0%	13%
10	Reos				1		1	1			**3**
		0%	0%	0%	5%	0%	7%	7%	0%	0%	3%
11	Vol.Col.'s Spouses & Children		1				1	1			**3**
		0%	10%	0%	0%	0%	7%	7%	0%	0%	3%
12	Others Mentioned At Most Twice*					4	2	3			**9**
		0%	0%	0%	0%	15%	13%	21%	0%	0%	8%
	Total Number of Facilities	**5**	**10**	**12**	**19**	**27**	**15**	**14**	**4**	**1**	**107**
		5%	9%	11%	18%	25%	14%	13%	4%	1%	100%

Graph 18: Methods Used to Determine Who is too Poor to Pay

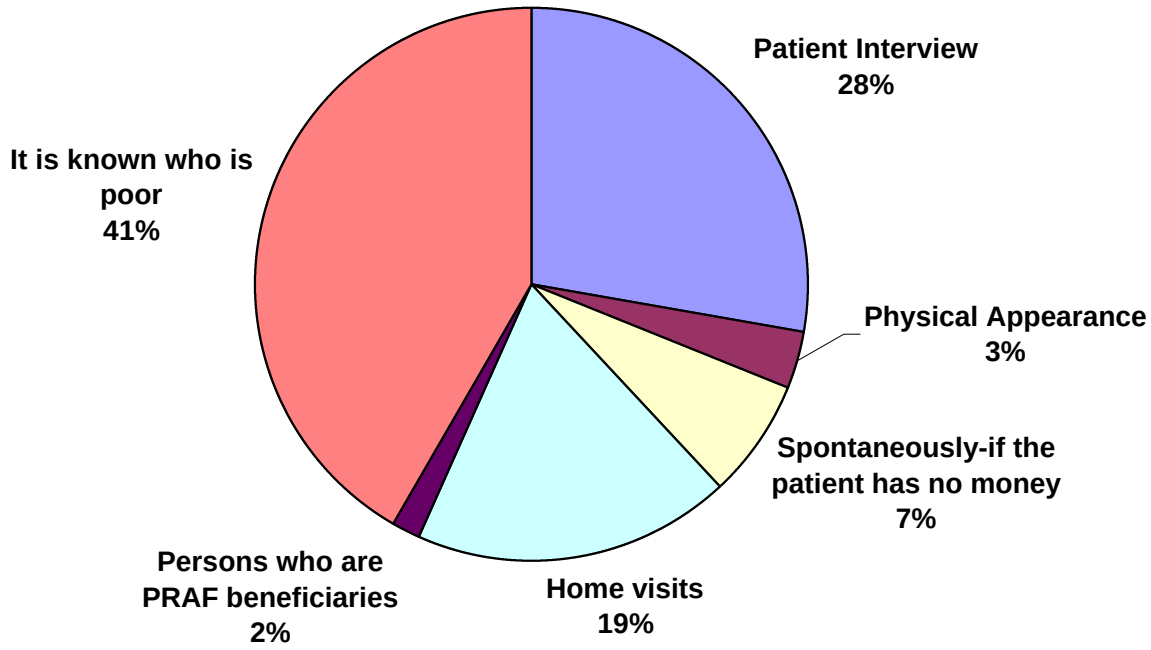


Table 25
Methods Used to Determine Who is Too Poor to Pay User Fees
By Type of User Fee System

Number and Percent of Responses
Multiple Responses Possible. Maximum Number was Two

Method	*Types of User Fee Systems*			All User Fee Systems
	Institutional	Community	Mixed	
Patient interview / Socioeconomic assessment	51	2	0	53
Percent of Responses	42%	4%	0%	28%
Persons who are PRAF beneficiaries	3	0	0	3
Percent of Responses	2%	0%	0%	2%
Spontaneously-if the patient has no money	4	7	2	13
Percent of Responses	3%	13%	17%	7%
Home visits	19	14	2	35
Percent of Responses	16%	25%	17%	19%
It is known who is poor	38	32	8	78
Percent of Responses	31%	58%	67%	41%
Physical appearance	7	0	0	7
Percent of Responses	6%	0%	0%	4%
Total	122	55	12	189
	100%	100%	100%	100%

In CESARs, which are generally staffed by a single, nurse auxiliary, conducting home visits to assess patients' ability to pay probably requires closing the facility, and thus is particularly expensive approach for this type of facility—in addition to the considerable staff time and possible travel costs, it exacts indirect costs in terms of health care not being available while the home visit is being made.

Table 26 shows the frequency of the different methods used by region. In seven of the eight regions for which there is adequate information, the most important method used is knowledge of the clientele. Generally the next most common method is patient interview. Home visits are particularly important in Comayagua and Copán, where they are the most frequently relied upon method.

As may be seen in Table 27, community and mixed user fee systems are about twice as likely to indicate "It is known who is poor," than is an institutional fee system. The institutional systems on the other hand are more likely to rely on a patient interview.

As Table 28 shows, in the institutional systems there are distinct patterns in terms of who is the primary agent determining which patients will be exempt from paying for care by virtue of their being considered indigent. In all three types of hospitals the determination is usually made by a social worker, although in area hospitals the decisions are oftentimes made by the facility director or administrator. In

Table 26
Methods Used to Determine Who is Too Poor to Pay User Fees
By Regional Office System

Number and Percent of Responses
Multiple Responses Possible. Maximum Number was Two.

Method	Metro-politan	San Felipe	Comaya-gua	San Pedro Sula	Choluteca	Copan	La Ceiba	Juticalpa	Puerto Lempira	All Regions
Patient interview / Socioeconomic assessment	2	9	5	5	6	4	5	6	0	42
Percent of Responses	33%	33%	21%	20%	19%	21%	22%	30%	0%	24%
Persons who are PRAF beneficiaries	1	0	0	0	0	2	0	0	0	3
Percent of Responses	17%	0%	0%	0%	0%	11%	0%	0%	0%	2%
Spontaneously-if the patient has no money	1	6	0	2	0	1	1	2	0	13
Percent of Responses	17%	22%	0%	8%	0%	5%	4%	10%	0%	7%
Home visits	1	1	9	7	3	9	5	0	0	35
Percent of Responses	17%	4%	38%	28%	9%	47%	22%	0%	0%	20%
It is known who is poor	1	11	9	11	22	2	10	12	0	78
Percent of Responses	17%	41%	38%	44%	69%	11%	43%	60%	0%	44%
Physical appearance	0	0	1	0	1	1	2	0	1	6
Percent of Responses	0%	0%	4%	0%	3%	5%	9%	0%	100%	3%
Total	6	27	24	25	32	19	23	20	1	177
Percent of Responses	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 27
Methods Used to Determine Who is Too Poor to Pay User Fees
By Type of Facility

Number and Percent of Responses
Multiple Responses Possible. Maximum Number was Two.

Method	*Type of Hospital*				CESAMOs	CESARs	All Facilities
	National	Regional	Area	All			
Patient interview / Socioeconomic assessment	6	5	12	23	18	12	53
Percent of Responses	100%	100%	75%	85%	24%	14%	28%
Persons who are PRAF beneficiaries	0	0	0	0	3	0	3
Percent of Responses	0%	0%	0%	0%	4%	0%	2%
Spontaneously-if the patient has no money	0	0	0	0	4	9	13
Percent of Responses	0%	0%	0%	0%	5%	10%	7%
Home visits	0	0	0	0	21	14	35
Percent of Responses	0%	0%	0%	0%	28%	16%	19%
It is known who is poor	0	0	0	0	27	51	78
Percent of Responses	0%	0%	0%	0%	36%	59%	41%
Physical appearance	0	0	4	4	2	1	7
Percent of Responses	0%	0%	25%	15%	3%	1%	4%
Total	6	5	16	27	75	87	189
Percent of Responses	100%	100%	100%	100%	100%	100%	100%

Table 28
MOH Facility Staff Persons Who Determine Which Patients are Too Poor to Pay for Care in Institutional User Fee Systems

Type of Facility	Number of Facilities	Types of Staff Persons								Total	Avg. Per Facility
		Director	Administrator	Cashier	Physician	Nurse	Auxiliary Nurse	Other*	Social Worker		
Primary Decisionmaker											
National Hospital	6								6	6	1.0
Regional Hospital	6	1		1					4	6	1.0
Area Hospital	16	4	6	1	1				7	19	1.2
CESAMO	56	2	3	12	13		29	1	3	63	1.1
CESAR	20				1		19			20	1.0
All Facilities	104	7	9	14	15	0	48	1	20	114	1.1
Secondary Decisionmaker											
National Hospital	6	1	1	2	1					5	0.8
Regional Hospital	6	1	2	2	1	1			1	8	1.3
Area Hospital	16	8	6		2	2	1	1		20	1.3
CESAMO	56	2		10	14	7	15			48	0.9
CESAR	20					1		2		3	0.2
All Facilities	104	12	9	14	18	11	16	3	1	84	0.8
All Persons Involved											
National Hospital	6	1	1	2	1				6	11	1.8
Regional Hospital	6	2	2	3	1	1			5	14	2.3
Area Hospital	16	12	12	1	3	2	1	1	7	39	2.4
CESAMO	56	4	3	22	27	7	44	1	3	111	2.0
CESAR	20	0	0	0	1	1	19	2	0	23	1.2
All Facilities	104	19	18	28	33	11	64	4	21	198	1.9

CESAMOs it is usually a nurse auxiliary who is responsible, although it is also common for the user fee cashier or a physician to be the chief decision-maker.

Table 29 presents the same information for community and mixed systems. The primary persons determining who has the capability to pay for care in these systems are nurse auxiliaries, reflecting the fact that most of these systems (83 percent) are found in CESARs. In about one in eight community systems and in nearly half of the mixed systems, local Health Committees are the primary agents determining which patients will be exempt because they are regarded as medically indigent.

In a particular facility, the person with primary responsibility to determine a patient's pay status depends on the type of facility it is (which reflects its staffing pattern), and it depends on the whether or not there are persons whose main responsibility is the administration of the user fee system. The higher levels of care with their greater division of labor and larger staffs generally have persons who spend a substantial proportion of their work-time administering the user fee system. In hospitals, these persons include social workers (to identify who must pay for care and who is exempt), cashiers and accountants.

4.9 Probability of Payment by Level of Care

The National Survey of Household Income and Expenditures was reviewed to help address this information gap concerning the frequency of non-payment—for whatever reason, categorical or medical indigency. Persons obtaining outpatient care for an acute illness are more likely to pay for their care at CESARs than at CESAMOs and much more likely to pay at a CESAMO than at an MOH hospital. (See Graph 19 for details.) Slightly less than half (49 percent) of the outpatients of the MOH hospitals pay for care, compared to 87 percent who are treated at a CESAR or CESAMO. **The relative rates at which persons are exempted from payment at the different levels of MOH care are encouraging the inefficiency of the Ministry of Health.** These practices are sending the wrong signals to MOH would-be patients and encouraging them to use the hospitals as their first source of outpatient care, then the CESAMOs and last, the CESARs. These relative rates of exoneration are encouraging the use the pyramidal referral system from the top-down, just the opposite of what is intended.

4.10 The Average Effective Price of a General Consultation by Level of Care

When the probability of payment information is combined with (multiplied by) the standard general consultation price we can derive an average effective price of a general consultation visit at each type of MOH facility. As Graph 20 shows, the highest average effective price for a general consultation are at the least costly, lowest tier of care and the lowest fees are the highest cost, highest tier of care, just the opposite of what it should be. Graph 21 expresses the differences in effective prices as a percent of that of CESARs'. There is a need to reform these relative fee levels and the practices of granting exemption from payment.

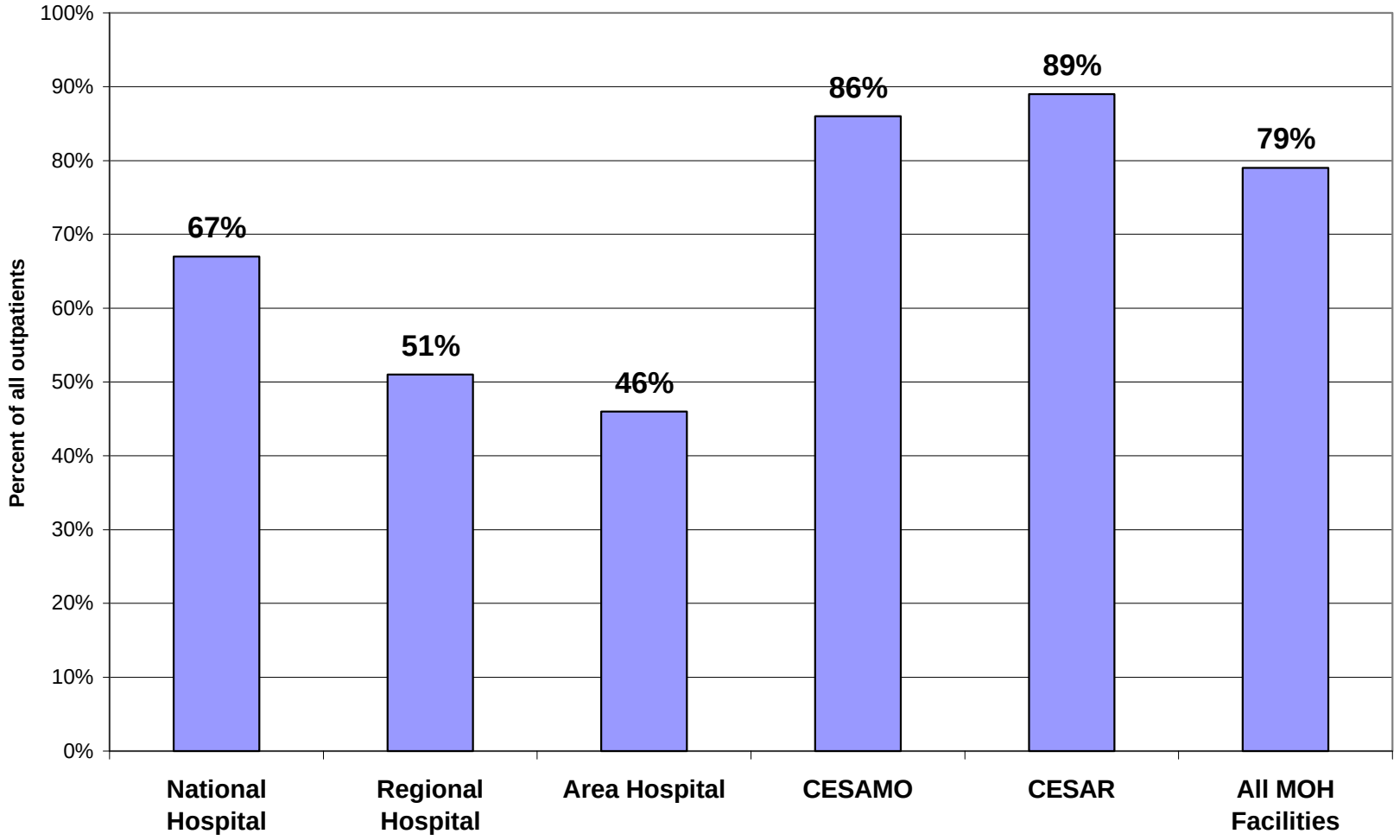
4.11 Changes in User Fees

The Regulation and Manual for Recovered Funds states that there will be periodic revisions of price levels by the individual National, Regional and Area Hospitals and CESAMOs with "pre-approval of the Central Level and in agreement with the level of care provided and the socio-economic situation of the community" (page 5). In another section of the report (page 10), it states that "all MOH facilities, with the exception of health centers with community systems, will charge for services that are provided to the public the established tariff (which will be revised periodically by the competent entity of the MOH)." Two observations are in order. First, CESARs are not included in the list, suggesting that their fees will

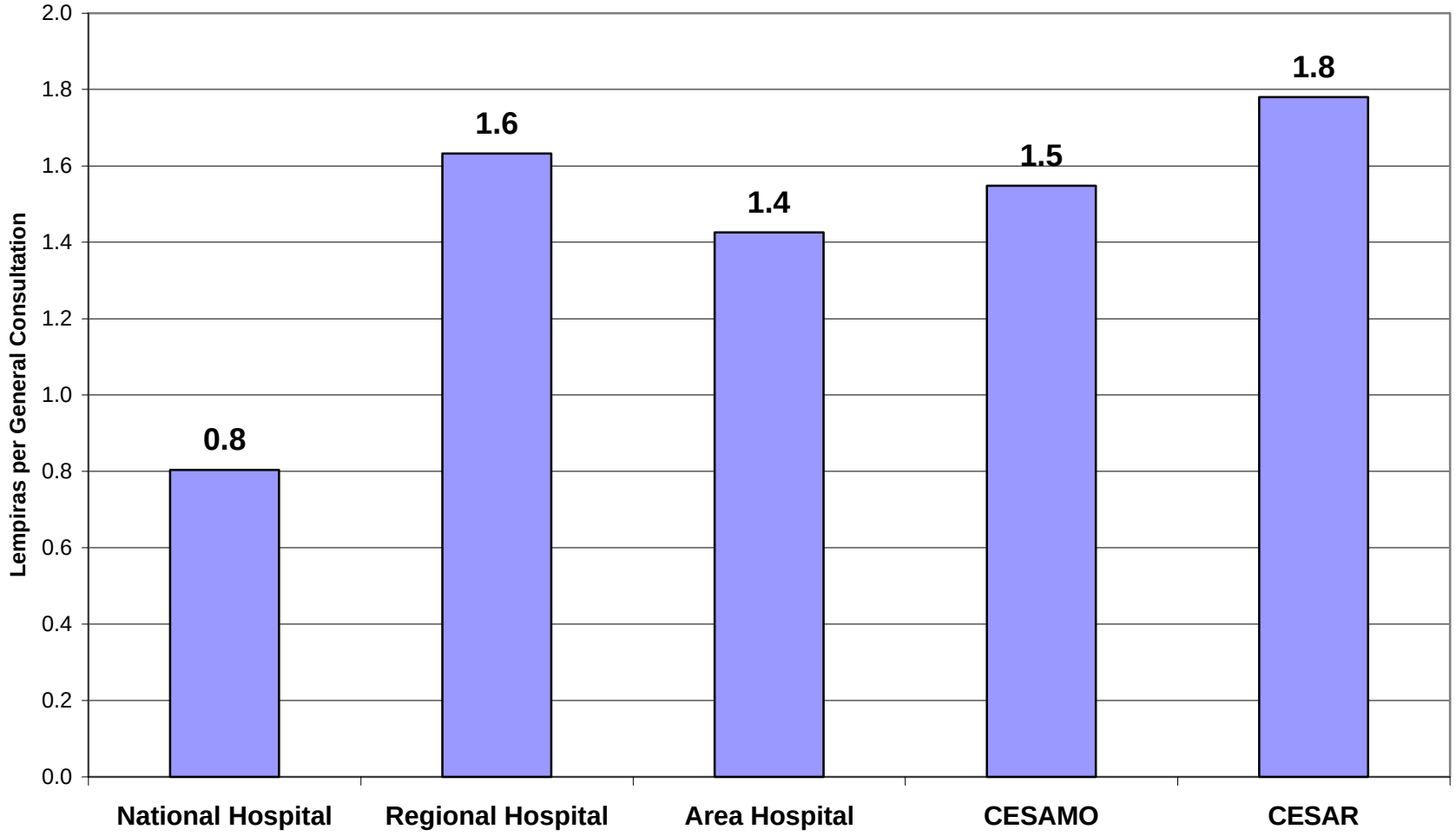
Table 29
MOH Facility Staff Persons Who Determine Which Patients are Too Poor to Pay for Care in Community User Fee Systems

Type of UF System/ Type of Facility	Number of Facilities	Types of Staff Persons						Total	Average Per Facility
		Director	Health Committee	Health Guard	Physician	Auxiliary Nurse	Other*		
COMMUNITY SYSTEMS									
Primary Decisionmaker									
CESAMO	5	0	1	0	3	1	0	5	1.0
CESAR	60	1	7	0	0	49	3	60	1.0
All Facilities	65	1	8	0	3	50	3	65	1.0
Secondary Decisionmaker									
CESAMO	5	0	0	1	1	1	0	3	0.6
CESAR	60	0	16	2	0	6	2	26	0.4
All Facilities	65	0	16	3	1	7	2	29	0.4
All Persons Involved									
CESAMO	5	0	1	1	4	2	0	8	1.6
CESAR	60	1	23	2	0	55	5	86	1.4
All Facilities	65	1	24	3	4	57	5	94	1.4
MIXED SYSTEMS									
Primary Decisionmaker									
CESAMO	8	0	4	0	0	4	0	8	1.0
CESAR	4	0	1	0	0	3	0	4	1.0
All Facilities	12	0	5	0	0	7	0	12	1.0
Secondary Decisionmaker									
CESAMO	8	2	1	0	3	0	0	6	0.8
CESAR	4	0	0	0	0	0	2	2	0.5
All Facilities	12	2	1	0	3	0	2	8	0.7
All Persons Involved									
CESAMO	8	2	5	0	3	4	0	14	1.8
CESAR	4	0	1	0	0	3	2	6	1.5
All Facilities	12	2	6	0	3	7	2	20	1.7

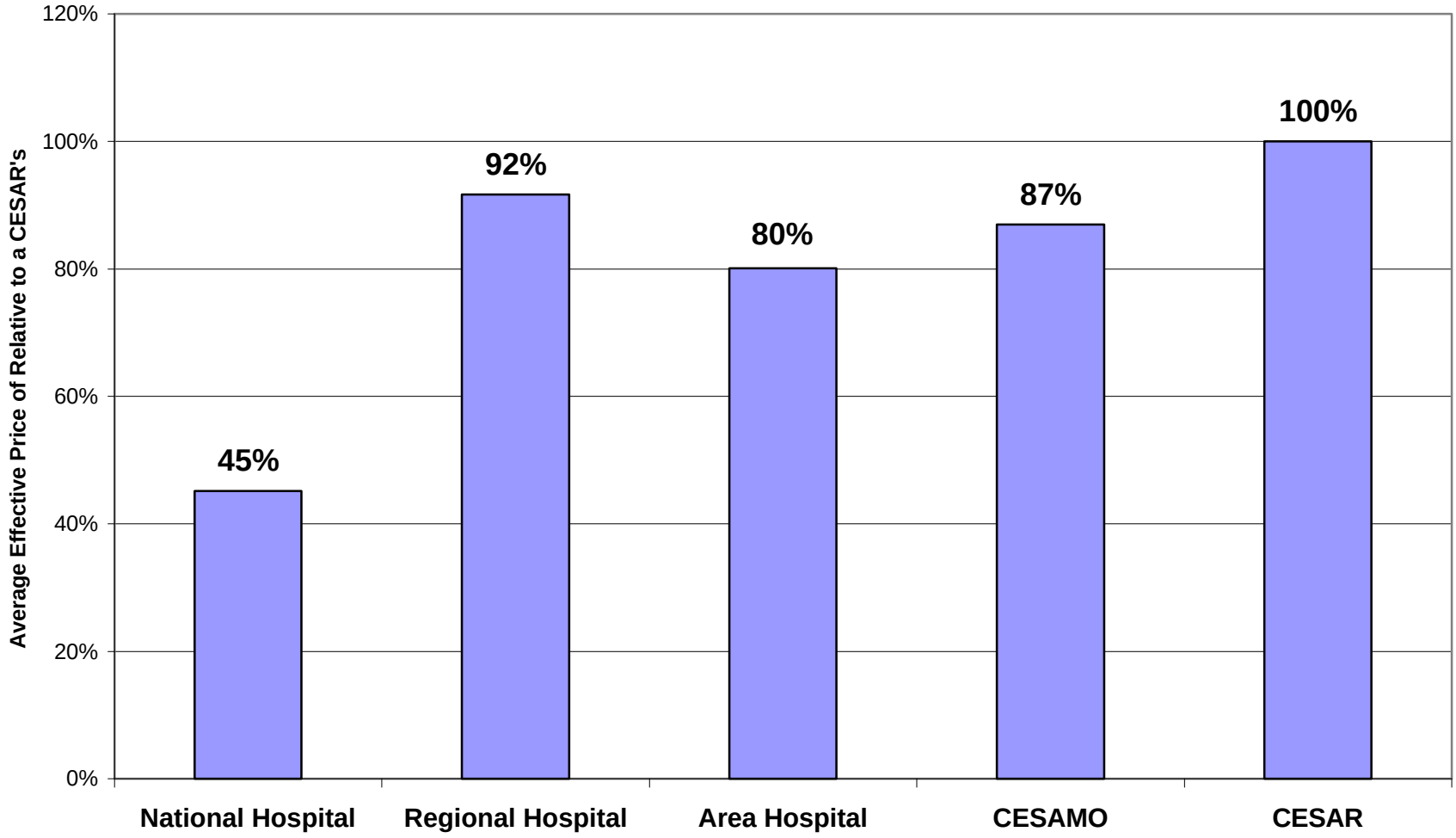
Graph 19: Proportion of Persons Who Paid for Their Acute Care Outpatient Visit



Graph 20: Average Effective Price of a General Consultation
(Probability of Payment Multiplied by Standard Fee)



Graph 21: Average Effective Price of a General Consultation in Each Type of MOH Facility Relative to that of a CESAR



remain constant, in perpetuity. Second, the ambiguous wording "competent entity of the MOH" is a source of confusion and uncertainty. Frequently it is judged to be the regional office that has the authority for changing prices, though the previous quotation explicitly states it is the central level. The uncertainty about who has the authority to revise fee levels has proven to be an obstacle to their being changed.

Fifty percent of the interviewees reported that user fee levels have never been modified since the system was first established.[14] Those that have changed their fee levels reported that they had last done so, on average, two years ago. As may be seen in Table 30, institutional systems are less likely than community systems to have ever changed their fee levels, despite the fact the institutional systems, on average, are three times older (with a median age of 10 years, compared to 3 for community systems). Furthermore, as Table 31 shows, those institutional systems that have modified their fees last did so, on average, about 3 years ago. In contrast, the community systems that have changed their fee levels reported, on average, that the last time they did so was about a year and a half ago.

Reviewing the regions' data in the last two tables prompts to two observations. First, it is noteworthy that in terms of both the number of facilities that have ever changed their fee levels and, among those that have, that there is considerable intra-regional variation. This suggests that the regional offices have not pursued (at least not successfully) a uniform policy with regard to initiating changes in user fee levels. (In the case of community systems, the fee levels are the decision of the community.)

A second interesting pattern emerges from a closer inspection of the regions' data. The regions where a larger proportion (more than 50 percent) of facilities report they have changed their fees at least once, have not done so, on average, for a longer period of time relative to those regions wherein there have been fewer facilities that have ever changed their fee levels. It may be inferred that there is a new dynamic developing in the regions that traditionally have only very rarely, if ever, made modifications in user fee levels: a handful of the facilities in the region have very recently started to change their fees.

This same type of pattern exists for hospitals, as well: there is an inverse relationship between the proportion of facilities that have modified their user fees at least once, and the number of years on average since those that have changed their fees, last did so. Among the three types of hospitals, the national hospitals have the smallest proportion reporting ever having changed their fees. At the other extreme are the area hospitals, 81 percent of which have changed their charges. The area hospitals were the facility type most likely to have revised their fees.

4.11.1 The Cost of Not Changing Fee Levels: The Impact of Inflation on User Fee Prices

It is important to think about what has happened to the purchasing power of the lempira in the past few years and what the impact of inflation has been on what user fees can purchase. In short, it is essential to examine how the real value of user fees has changed. Table 32 shows the behavior of the gross domestic product (GDP) deflator, one measure of inflation, from 1990 through 1999, and the impact

[14] Interviewers were instructed to request official documentation for both the starting year and the last change in user fees. The extent to which they did so, however, was not ascertained. Therefore, it may be that responses to the question as to whether the facility had "ever" modified its user fees, may reflect the tenure of the respondent at the facility.

Table 30
Changes in User Fees

Characteristic	Number of Respondents	User Fee Levels Have Been Changed at Least Once	
		Number	Percent
Type of User Fee System			
Institutional	104	50	48%
Community	66	38	58%
Mixed	15	4	27%
Region*			
Metropolitana	4	1	25%
San Felipe	25	13	52%
Comayagua	24	15	63%
San Pedro Sula	26	10	38%
Choluteca	30	11	37%
Copan	17	13	76%
La Ceiba	26	12	46%
Juticalpa	19	11	58%
Puerto Lempira	1	1	100%
Regions' Total:	172	87	51%
Type of Facility			
National Hospital	6	1	17%
Regional Hospital	6	4	67%
Area Hospital	16	13	81%
All Hospitals	28	18	64%
CESAMOs	71	31	44%
CESARs	86	43	50%
All Facilities	**185**	**92**	**50%**

Table 31
Changes in User Fees:
Average Number of Years Since Last Change

Analysis Limited to Only Those Facilities That Reported
They Have Changed Their User Fee Levels at Least Once

Characteristic	Number of Respondents	Years Since Last Change in User Fees	
		Mean	Median
Type of User Fee System			
Institutional	49	3.6	3.0
Community	38	1.7	1.5
Mixed	4	1.8	1.5
Region*			
Metropolitana	1	0.0	0.0
San Felipe	13	1.4	1.0
Comayagua	15	5.0	3.0
San Pedro Sula	10	2.1	1.0
Choluteca	10	1.5	1.0
Copan	13	4.0	4.0
La Ceiba	12	1.0	1.8
Juticalpa	11	2.4	2.0
Puerto Lempira	1	5.0	5.0
Regions' Total	86	2.8	2.0
Type of Facility			
National Hospital	1	1.0	1.0
Regional Hospital	4	2.5	2.5
Area Hospital	13	3.7	4.0
All Hospitals	18	3.3	3.5
CESAMOs	30	3.7	3.0
CESARs	43	1.8	1.0
All Facilities with One or Change	**91**	**2.7**	**2.0**

Table 32
The Impact of Inflation on a Fixed Nominal Price of 2.00 Lempiras

Year	GDP Deflator	Price of a Consultation		Price if Real Value Maintained Constant
		Nominal	Real	
1990	100.0	2.00	2.00	2.00
1991	124.4	2.00	1.61	2.49
1992	138.0	2.00	1.45	2.76
1993	156.9	2.00	1.27	3.14
1994	191.9	2.00	1.04	3.84
1995	247.9	2.00	0.81	4.96
1996	307.2	2.00	0.65	6.14
1997	380.0	2.00	0.53	7.60
1998	418.3	2.00	0.48	8.37
1999	468.7	2.00	0.43	9.37

it has had on a fixed consultation fee of 2.00 lempiras.[15] The average institutional user fee system was started in 1990 and the average user fee for a general consultation is 2.00 lempiras. A 2.00 lempira fee established in 1990 and never changed would have been worth 43 centavos in real terms in 1999. Following such a pricing policy would have meant that the facility would have lost 78 percent of the purchasing power of their standard user fee over the past decade.

Not all user fee systems have experienced this level of erosion in their real income, but half of them have. Half of them have never changed their fee levels. The other half that have changed their nominal levels last did so, on average, more than three years ago. If they raised their fee level to 2.00 lempiras in 1996, by 1999 the real value of that fee was 1.31 lempiras. **If the purpose of the user fee system is to recover some of the costs of providing care so that supplementary inputs can be purchased so as to enhance the quality of care provided, over the past decade the ability of the user fee system to serve this function has been seriously eroded by inflation.**

[15] The ideal measure of inflation in this instance is depends on what the composition of purchases that MOH facilities make with user fees and whether they generally pay retail or wholesale prices. Over this period the CPI and the GDP deflator changed by similar amounts, 155 and 153 percent, respectively. An analysis of the medical care price component of the CPI from 1995 through 1998 found that it increased less rapidly than the overall CPI over that four-year period. The annual average of the CPI was 27.2 percent per year, compared to 21.9 percent for just the medical care price component. In 1999 and 2000, these relative rates changed and the medical care price component increased at a rate more than double that of the general CPI from first quarter 1999 to first quarter 2000. While a more definitive analysis would require more detailed information about the purchases made with user fee revenues, it is clear that the value of the user fees has been seriously eroded by the relatively high general level of inflation that has plagued Honduras throughout the decade of the 1990s.

The right hand column of Table 32 shows how a 2.00 lempira user fee would have had to change each year (assuming the level of care provided and the proportion of free care provided did not change) in order to maintain the purchasing power of 1990 user fee levels.

To maintain the purchasing power of a user fee, its level must be increased each year by the amount of inflation. Measuring inflation by the GDP deflator, on average each year from 1990 through 1999, user fees should have been increased by 22.3 percent to maintain the purchasing power of the revenues generated.

4.11.2 Inflation Has Increased the Administrative Burden of RFRM Regulations

The UFSs have been squeezed by inflation in another way as well. The RMRF ceiling of 2,000 lempiras on the amount of revenues that can be maintained in their rotating funds has clearly become an increasingly constraining Regulation as the purchasing power of 2,000 lempiras in 1990 fell to the equivalent of only 426.71 lempiras in 1999. To have maintained the purchasing power of those 2,000 lempiras would have meant that the ceiling would have been 9,374 lempiras in 1999.

Inflation has also meant that the RMRF's maximum allowable purchase before requiring three price quotes, which was 100 lempiras in 1990 has become increasingly constraining. To have retained the purchasing power of 100 1990 lempiras, the ceiling would have to have been increased to 468.70 lempiras in 1999. The impact of inflation was not anticipated in the RMRF and has clearly and dramatically increased the administrative burden of adhering to RMRF Regulations.

4.12 Why User Fee Levels Have Never Been Changed

In those facilities where it was reported that fees have ever been changed since the user fee system was first introduced, respondents were asked why there never been any changes. Graph 22 shows their responses. Half of the interviewees attributed the inaction to their regional office, and another three percent said they had lacked the support of the MOH Central Office to do so.

Table 33 shows various breakdowns of the explanations by type of facility and Table 34 contains the responses by type of UFS. It is interesting to note that in some instances—36 percent of the community system respondents (n = 10)—the regional office was cited as the obstacle to change, when in fact the regional office does not have legally-established authority over these entities. It is the health committee that has the authority. It is clear that there is a need to educate facility directors and administrators, and more generally MOH employees and the general Honduran public about the RMRF (incorporating, of course, any reforms that are enacted in response to this review and dialogue).

Table 35 shows the responses of just the area hospitals, CESARs and CESAMOs by region. Here, the lack of action is attributed even more regularly to the regional office. This is the attribution of 55 percent of respondents, and in three of the regions it constitutes two-thirds or more of the justifications provided.

4.13 Institutional UF Levels: The Views of the Regional Offices

Representatives of all nine of the MOH regional offices were interviewed. Seven of the interviewees were the directors of the office and two were the administrators. All nine respondents

Graph 22: Explanations Why 50 Percent of Surveyed Facilities Have Never Modified Fees Since Their User Fee System was First Implemented

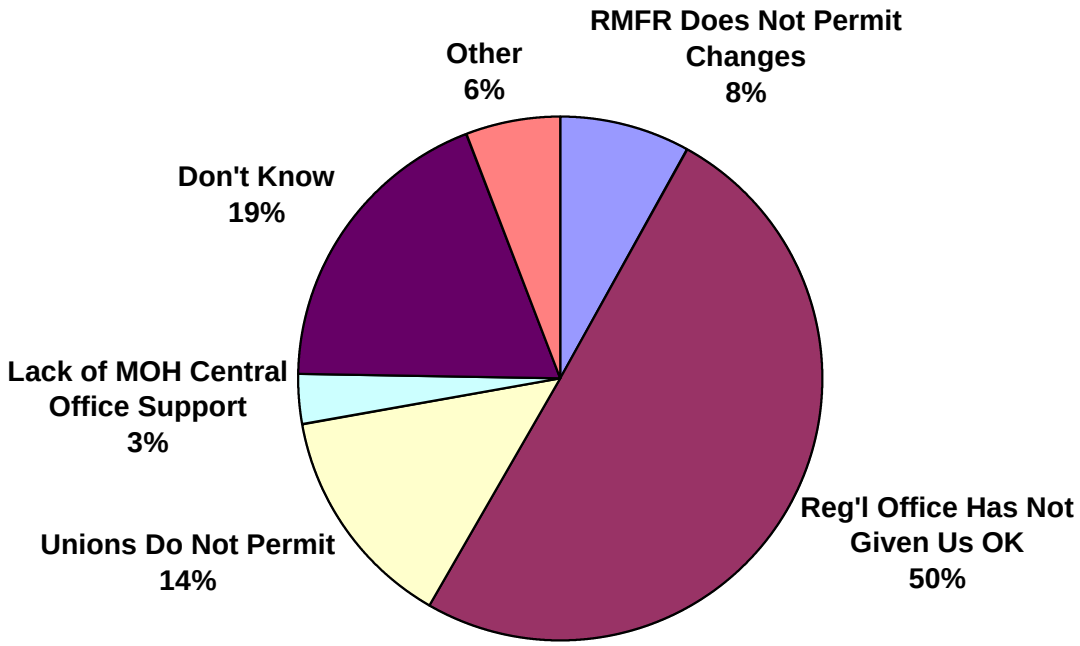


Table 33
Facilities' Explanations of Why They Have Never Changed Their User Fee Levels by Type of Facility

Analysis Limited to Only Those Facilities That Reported They Had Hever Changed Their User Fee Levels
(Multiple Responses Were Possible)

Type of Facility	Number of Respondents	Number of Responses	RMFR Does Not Permit Changes	Regional Office Has Not Given Us the Authority to Do So	The Unions Do Not Permit It	Don't Know	Lack of Support from the MOH Central Level	Other*
National Hospital	5	7	1	1	3	0	2	0
Percent of Responses			14%	14%	43%	0%	29%	0%
Regional Hospital	2	3	2	0	0	0	1	0
Percent of Responses			67%	0%	0%	0%	33%	0%
Area Hospital	3	3	0	1	2	0	0	0
Percent of Responses			0%	33%	67%	0%	0%	0%
All Hospitals	10	13	3	2	5	0	3	0
Percent of Responses			23%	15%	38%	0%	23%	0%
CESAMOs	40	44	5	27	4	8	0	0
Percent of Responses			11%	61%	9%	18%	0%	0%
CESARs	43	44	0	22	5	11	0	6
Percent of Responses			0%	50%	11%	25%	0%	14%
All Facilities	93	101	8	51	14	19	3	6
Percent of Responses			8%	50%	14%	19%	3%	6%

Table 34
Facilities' Explanations of Why They Have Never Changed Their User Fee Levels by Type of User Fee System

Analysis Limited to Only Those Facilities That Reported They Had Hever Changed Their User Fee Levels
(Multiple Responses Were Possible)

Type of User Fee System	Number of Respondents	Number of Responses	RMFR Does Not Permit Changes	Regional Office Has Not Given Us the Authority to Do So	The Unions Do Not Permit It	Don't Know	Lack of Support from the MOH Central Level	Other*
Institutional	54	62	8	35	9	6	3	1
Percent of Responses			13%	56%	15%	10%	5%	2%
Community	28	28	0	10	4	11	0	3
Percent of Responses			0%	36%	14%	39%	0%	11%
Mixed	11	11	0	6	1	2	0	2
Percent of Responses			0%	55%	9%	18%	0%	18%
All Facilities	93	101	8	51	14	19	3	6
Percent of Responses			8%	50%	14%	19%	3%	6%

Table 35
Facilities' Explanations of Why They Have Never Changed Their User Fee Levels
By Region

Analysis Limited to Only Those Facilities That Reported They Had Hever Changed Their User Fee Levels
(Multiple Responses Were Possible)

Region*	Number of Respondents	Number of Responses	RMFR Does Not Permit Changes	Regional Office Has Not Given Us the Authority to Do So	The Unions Do Not Permit It	Don't Know	Lack of Support from the MOH Central Level	Other*
Metropolitana	4	5	2	3	0	0	0	0
Percent of Responses			40%	60%	0%	0%	0%	0%
San Felipe	12	13	0	8	3	2	0	0
Percent of Responses			0%	62%	23%	15%	0%	0%
Comayagua	9	9	0	6	0	2	0	1
Percent of Responses			0%	67%	0%	22%	0%	11%
San Pedro Sula	16	17	1	9	2	5	0	0
Percent of Responses			6%	53%	12%	29%	0%	0%
Choluteca	19	21	1	15	2	0	0	3
Percent of Responses			5%	71%	10%	0%	0%	14%
Copan	4	4	0	4	0	0	0	0
Percent of Responses			0%	100%	0%	0%	0%	0%
La Ceiba	14	14	1	5	1	5	0	2
Percent of Responses			7%	36%	7%	36%	0%	14%
Juticalpa	8	8	0	0	3	5	0	0
Percent of Responses			0%	0%	38%	63%	0%	0%
Puerto Lempira	0							
Percent of Responses								
Regions' Total	86	91	5	50	11	19	0	6
			5%	55%	12%	21%	0%	7%

indicated that they were aware of the RMFR, and 7 (78 percent) of them had a copy of the manual that they showed to the interviewer.

When asked who determines the level of fees, the two most common responses were that the fees are established by the RMFR and that the UPS may make suggestions, but that the regional office is the ultimate authority. Three interviewees, one-third of the regional offices, indicated each of these responses. Table 36 shows, all of the responses. Four of the nine interviewees reported that all of the CESARs and CESAMOs in their regions have the same level of institutional user fees. When the regional office representatives of these regions were asked who determines the level of fees two of them said the fees were established by the RMFR, one said the MOH central office established them and one reported that the Director of the region makes the determination. Thus, three of the four respondents that stated that all fees are the same in all CESARs and CESAMOs in their regions regard fee levels as something that is beyond their control and outside of their authority.

Table 37 presents responses to the question as to how institutional UF levels are determined. By far the most common response was that the fee levels are set so as to cover the costs of providing the service in question. This was the response of 5 (56 percent) of the interviewees and its frequency was more than twice the next most common response. Three of the four respondents indicating that all fees of all CESARs and CESAMOs in their region are the same, also said that fees were set to cover the costs involved. By implication, these three respondents (one-third of the regional office directors) apparently believe that the cost of producing a particular service in a CESAMO is identical to the cost of providing it in a CESAR. This is most unlikely, and reflects the near total absence of information or studies about the cost of services provided by MOH facilities.

Two of the interviewees reported that institutional UF levels have never been changed. Both of these respondents were among those who indicated that they regarded control of fee levels to be outside of their authority (one reported that they were set by the MOH Central Office, the other that the RMFR established them). When asked why fee levels in their regions had not changed they responded that the RMFR does not give them the authority to change fees. The remaining seven interviewees reported that fees have changed at least once. In two regions it is reported that all of the UPSs have changed their fees at least once. In the remaining five regions, only some of the UPSs have increased their fees. In the regions where fees have changed, it has been 24 months since the last change. In sum, on average, institutional user fee levels have not changed frequently and have not been increased much in nominal terms. In real terms, the average user fee levels in Honduras have been steadily decreasing for the past decade.

Table 36
Who Determines the Level of the Fees In the Institutional User Fee System?

Responses of the Surveyed Regional Office Personnel

(Nine Interviewees)

Responses	Number of Interviewees	Percent of Regions
The UPS makes suggestions but the Regional Office has to authorize the levels	3	33%
The fees are established by the manual (RMFR)	3	33%
The UPS together with the community	1	11%
The community and the municipality	1	11%
The Ministry of Health Central Office	1	11%
Total:	9	100%

Table 37
Regional Office Respondents' Views of How Institutional User Fee Levels are Determined

(Nine Interviewees)

Responses	Number of Interviewees	Percent of Interviewees
To reflect the costs involved Three indicated only this response One also noted the need to take into account the levels of poverty One also noted the need to take into account private sector fee levels	5	56%
According to the need of the UPS	2	22%
It is the suggestion/recommendation of others	1	11%
MOH Central Office sets the general level–actual payment varies and is determined by technical studies of the socioeconomic status of the patient	1	11%
Total:	9	100%

4.14 Conclusion

In conclusion, there is great diversity within regions and across regions in the level of user fees, in the types of user fees, in exoneration policies, in the role of the regional office, in the degree of involvement and oversight by the regional offices. While institutional UF systems have been ostensibly regulated by the RFRM for more than 10 years, the degree of adherence to the *Regulation* varies substantially by region, type of facility and, it appears, over time. The IS as set forth in the RFRM is most consistently adhered to in the CESAMOs, but even in the CESAMOs there is considerable deviation from the *Regulation*.

The RFRM grants the Regional Offices considerable discretion in operating the institutional system, but judging by the results, they have perhaps been granted too much authority, without adequate parameters or assistance in developing a monitoring system, or perhaps it has simply been too long since the systems have been reviewed. Fees are low and in real terms declining. Some of the regions that are better administered are poor performers by other measures. For instance, two of the regions containing what are, on average, the oldest institutional systems administer their systems in a manner that is generally consistent with the RFRM. Fees in both of those regions, however, have generally not been changed for three years or more, and real income has fallen dramatically over the past years. Other regional offices do a poor job of administering the ISs. One regional office operates a system in which it says 71 percent of the facilities have a "sporadic" institutional user fee system. Another regional office says the institutional systems have been replaced with community systems, and it (the regional office) therefore, has no oversight responsibilities. And yet, there are no functioning health committees—the singular criterion provided by the RFRM to define a CS. It would appear in this instance that the goals of "community participation" and "decentralization" are used as euphemisms to describe a regional office abrogating its responsibilities.

5. User Fee Revenues, Expenditures, Current Account Balances and Costs

5.1 Introduction

This chapter consists of seven sections. The next two will discuss institutional and community user fee system revenues. The institutional system revenues data are official MOH data from the reporting system described earlier. The community system data are estimated from the weighted sample of surveyed facilities. The next section briefly discusses institutional user fee expenditures, which is followed by a discussion of the current accounts balances of 1999 and an analysis of the 1996-1999 balances. The last two sections discuss the administrative costs of the institutional UF systems and their net revenues (i.e., the gross revenues minus the costs).

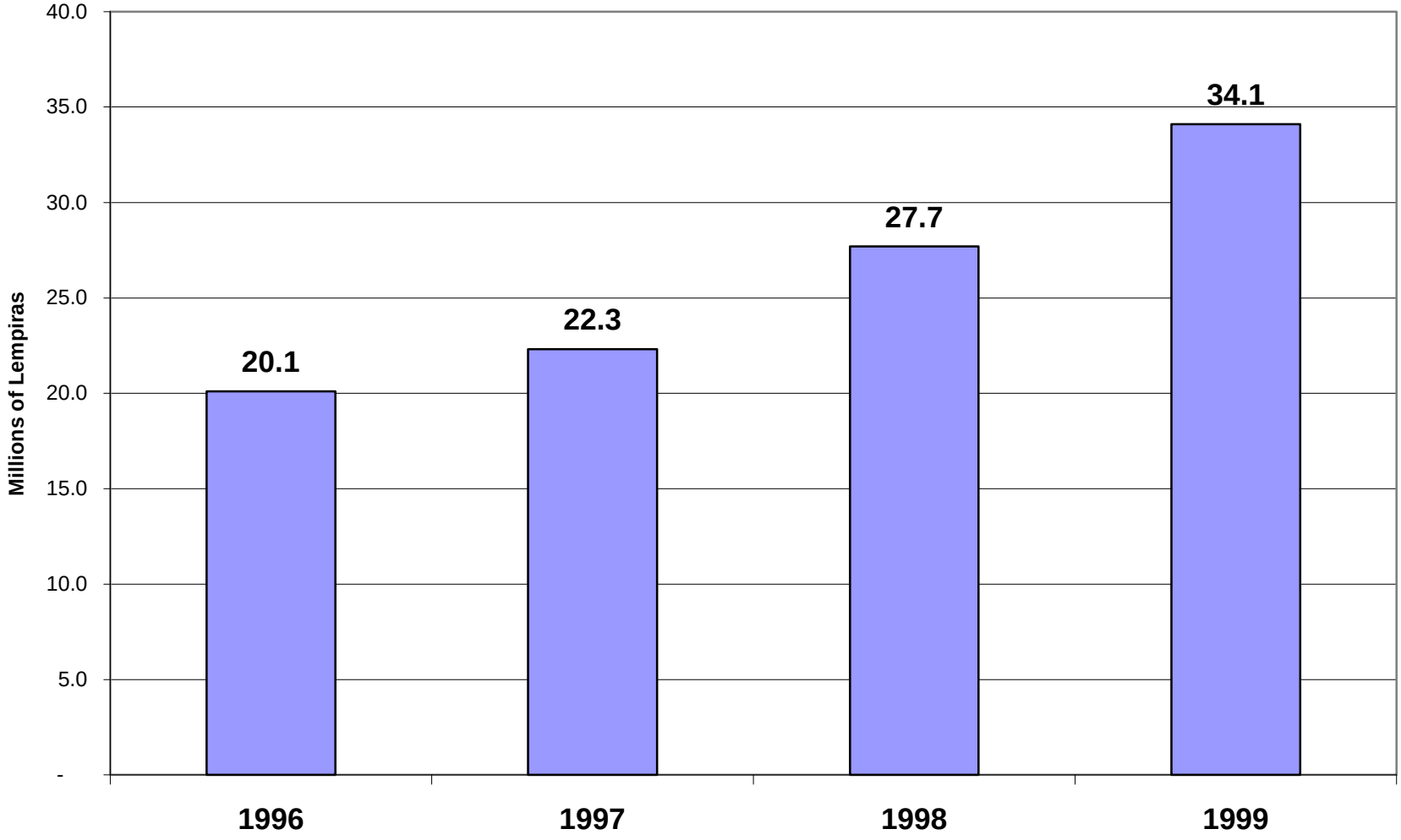
5.2 Institutional User Fee System Revenues

Although this study focuses on outpatient-related fees, the sums discussed in this section include inpatient-related revenues as well. The funds from these two types of care are commingled in the hospitals' accounts, thus precluding analysis of only the ambulatory care component.

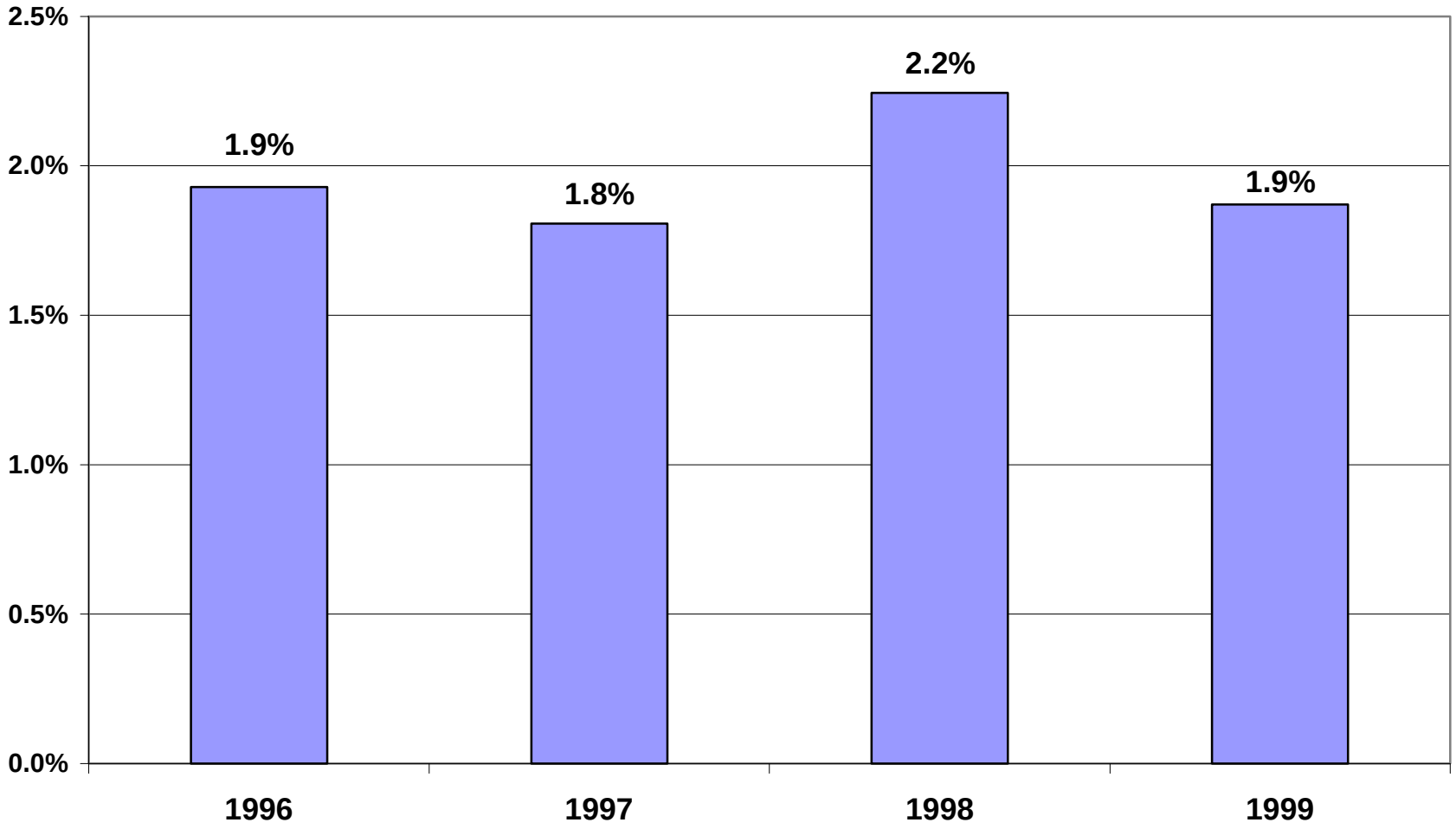
Graph 23 shows the annual totals of institutional user fee revenues from 1996 through 1999. User fees revenues grew at a brisk pace, annually averaging 23 percent. The 1999 total of 34 million lempiras, represented an increase of 70 percent over the 1996 figure. Closer examination, however, reveals a more troubling picture. Despite their rapid rate of growth in terms, however, the relative significance of institutional user fee revenues has been and remains modest. As may be seen in Graph 24, IUFS revenues as a proportion of total Central Government-funded MOH expenditures have remained small, hovering around two percent. Moreover, if this analysis is refined and the comparison includes only MOH expenditures on medical care (excluding Central Office administrative and environmental sanitation expenditures), the trend is more ambiguous (see Graph 25), and last year that indicator fell by more than half. Furthermore, if the impact of inflation on the purchasing power of institutional user fee revenues is taken into account, the trend of the last four years is not uniformly upward or pronounced. As Graph 26 shows, after falling by 10 percent in 1997, real revenues increased by an annual average of 12 percent from 1997 to 1999.

Graph 27 shows the sources of MOH user fee revenues by type of facility in 1999. The 28 MOH hospitals accounted for more three-quarters (76 percent) of total institutional user fee revenues and the national hospitals alone accounted for 39 percent. Disaggregating the trend analysis by type of facility (Graph 28) reveals that between 1996 and 1999 only the national hospitals enjoyed increased real user fee income. In real terms, their 1999 revenues were 142 percent their 1996 level, whereas the regional hospitals' was 42 percent less, the area hospitals' 45 percent less and the Regions (here defined as only the CESAMOs and CESARs) was only three-quarters of what it had been three years earlier.

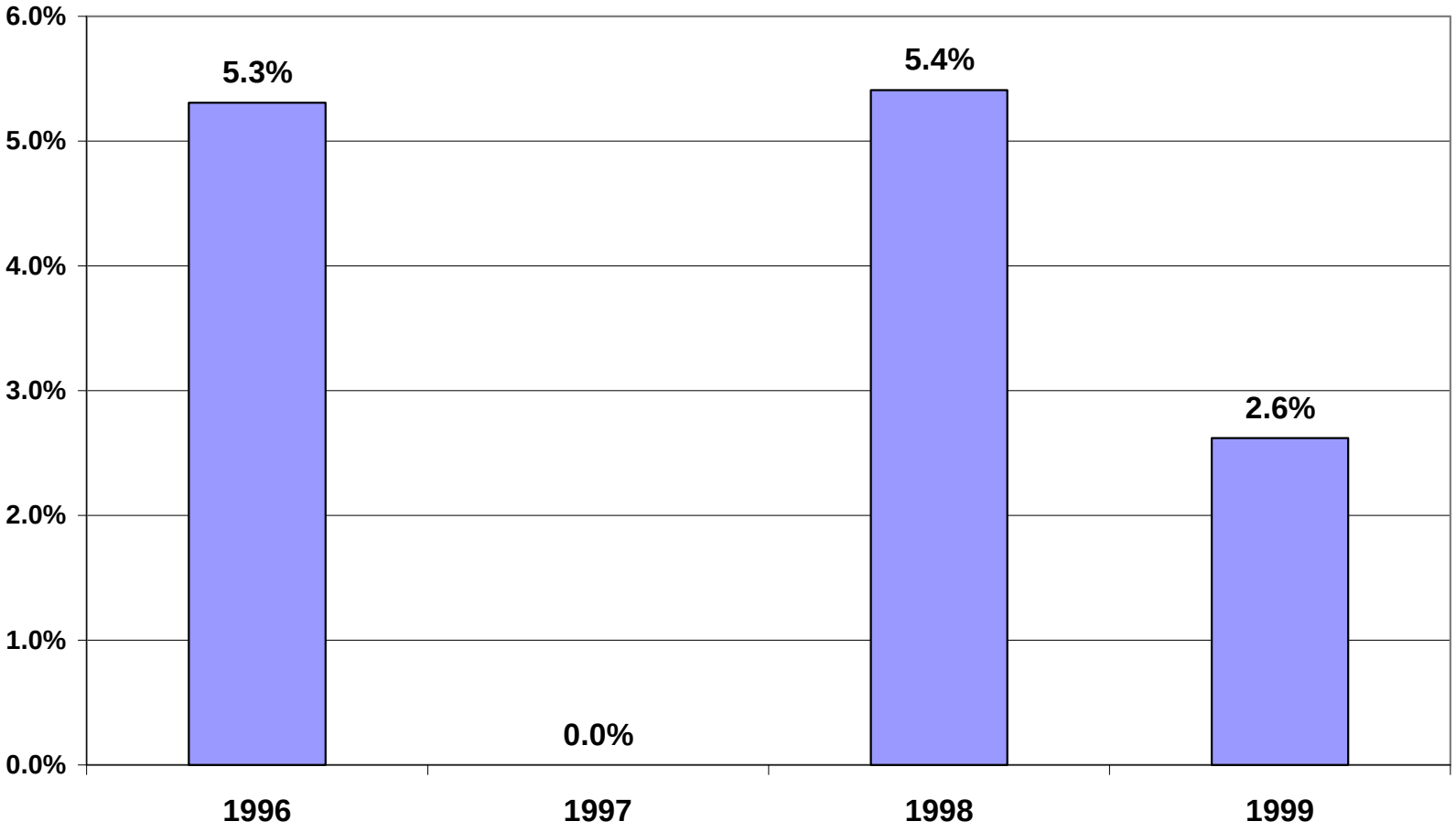
Graph 23: MOH Institutional User Fee Revenues



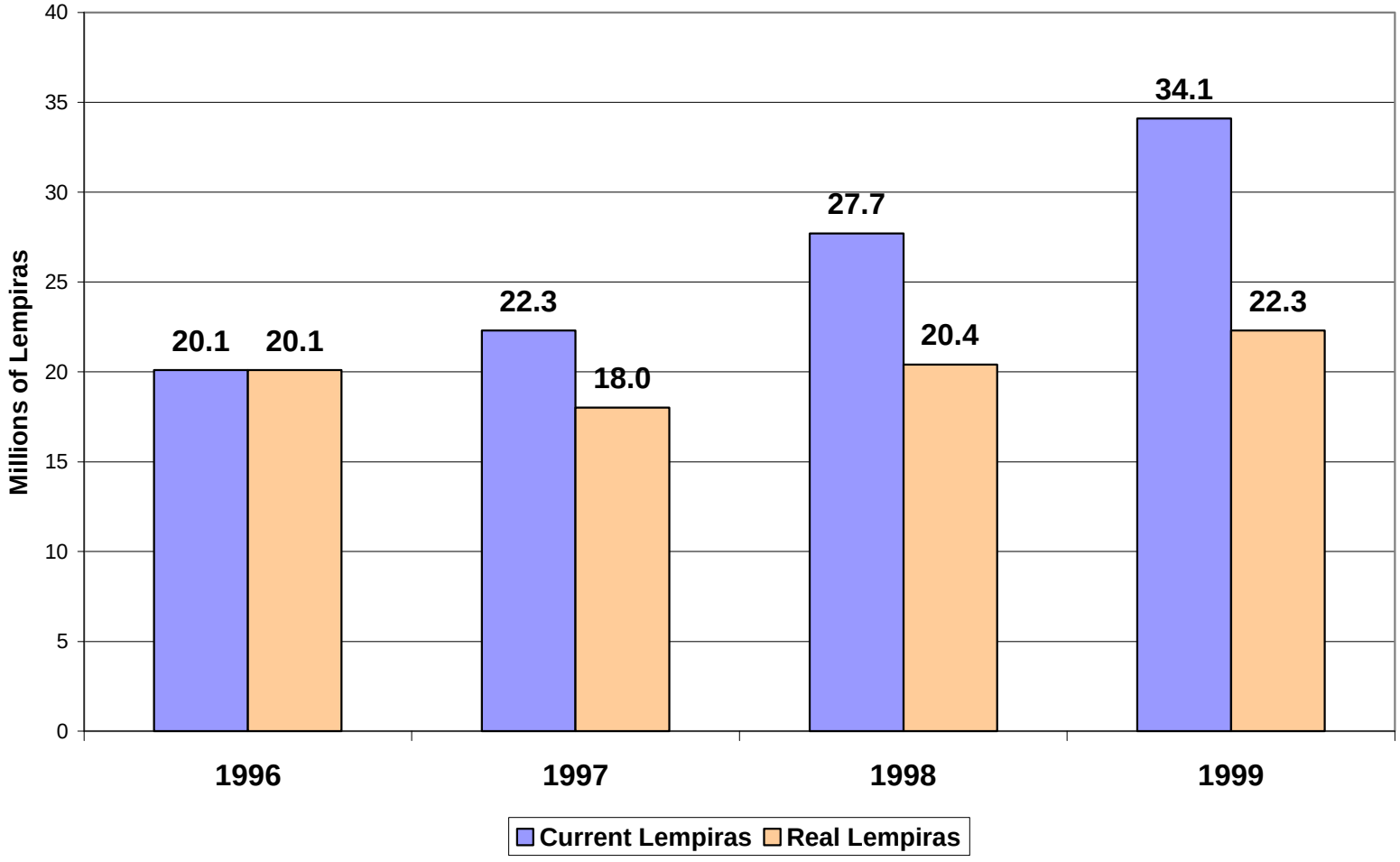
Graph 24: Institutional User Fee Revenues as a Percent of Total Central Government-Funded MOH Expenditures



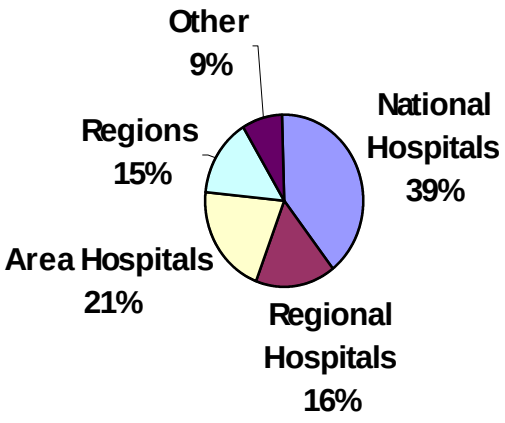
Graph 25: Institutional User Fee Revenues as a Percent of Central Government-Funded MOH Expenditures on Medical Care Provision



Graph 26: Institutional User Fee Revenues in Current and Real Lempiras



Graph 27: Sources of MOH 1999 Institutional User Fee Revenues, By Type of Facility

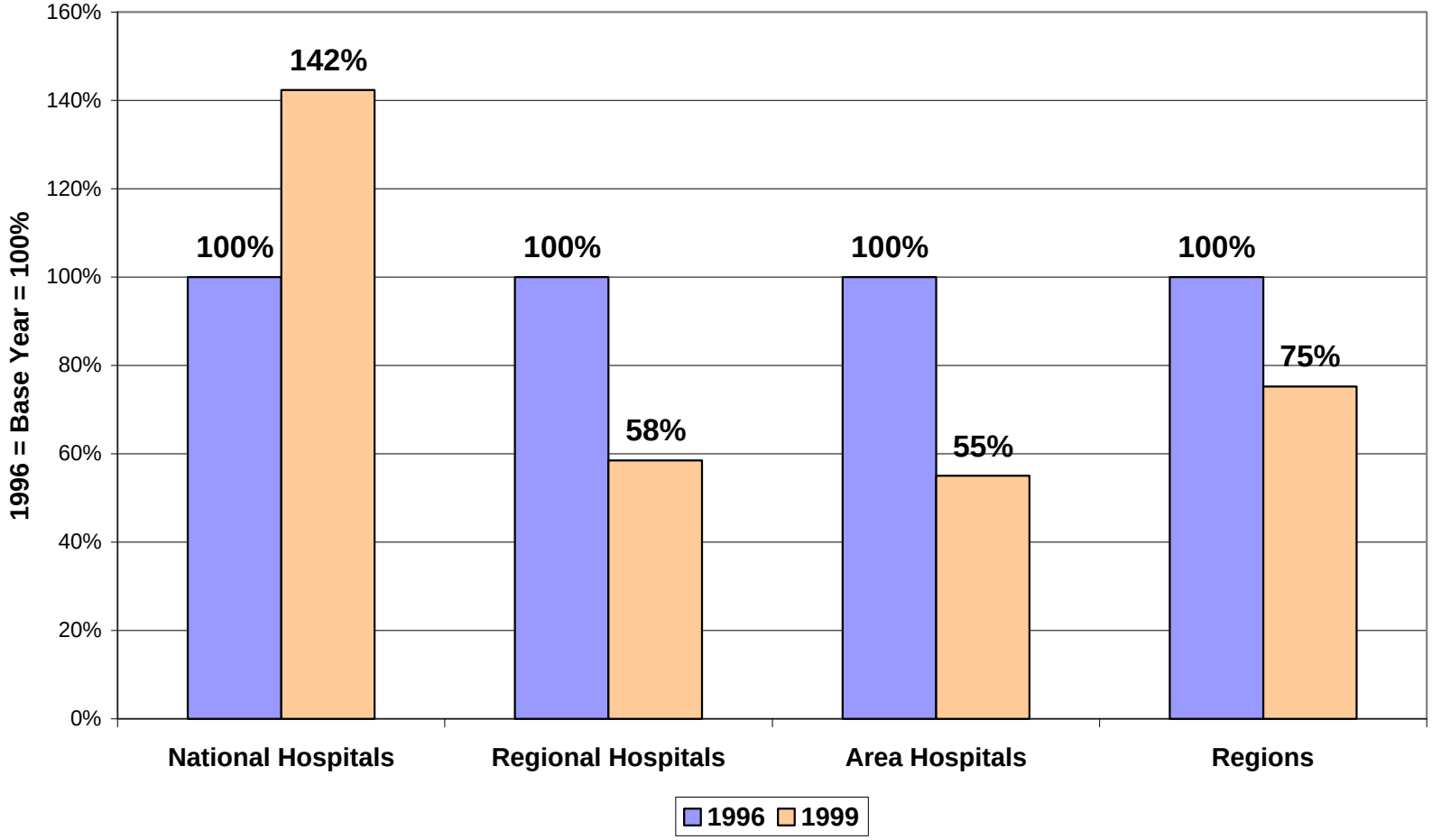


In summary, if the primary purpose of the Ministry's institutional user fee system is to generate income with which to defray costs, it has never been effective. Moreover, its effectiveness is faltering: it accounts for only a small and generally decreasing proportion of total costs. In area and regional hospitals and in CESAMOs and CESARs the institutional user fee systems are not holding their own: they are generating substantially less real income than they were four years ago. Only in the national hospitals has the performance trend been positive, but even there, (owing to the low amounts of revenue being brought in, 3.8 percent of total Central Government-funded expenditures) the systems cannot be regarded as being very effective.

5.2.1 User Fees, Fungible Resources and Incentives

It is important to note, however, that facility directors and administrators throughout the system point out that user fees are of disproportionately great importance (relative to their other resources) because these revenues constitute most of the fungible resources at the disposable of facility directors and administrators. For the most part, MOH resources are distributed in-kind, leaving relatively little room for the exercise of discretion and the actual purchase of the specific types and quantities of resources that a given facility might need. In contrast, user fees allow MOH staff to purchase exactly what they feel they need, (within the rules and regulations relating to their handling) as opposed to, at best, being able to choose from what is available from the MOH, and having to accept the uncertainties of when and if it will actually be delivered. This is an exceedingly important distinction to bear in mind throughout this discussion. It results in inefficiencies within the MOH system, as administrators are willing to use substantial amounts of existing MOH resources (e.g., personnel time) to obtain a much smaller value of liquid, fungible user fee revenues. While doing so may be economically irrational from a system perspective, from the individual administrator's/director's perspective it may be entirely rational.

Graph 28: Growth in the Real Value of Institutional User Fee Revenues 1996 to 1999 by Type of Facility



5.3 Community User Fee System Revenues and Total User Fee Revenues

Using the weighted sample, 1999 total community user fee system revenues are estimated to have been 3.7 million lempiras. Summing the estimated CS revenues and official data for IS revenues provides an estimate of total user fee revenues for 1999 of 37.8 million lempiras. The CSs' revenues constitute 11 percent of total MOH user fee revenues.

There is no data with which to examine trends in CS revenues, but it may be surmised that they have been increasing in recent years, at least in nominal terms. This inference is based on two observations. First, the reader will recall from the Chapter 4 discussion, that the bulk of CSs are young and that they have been increasing in number in recent years. Second, the number of MOH facilities has continued to increase throughout the past few years. Between 1997 and 1998, for instance, the number of CESARs increased by 69 (nine percent) and 15 new CESAMOs opened. Both of these factors have probably contributed to the growth in the number of CSs and in total CS revenues.

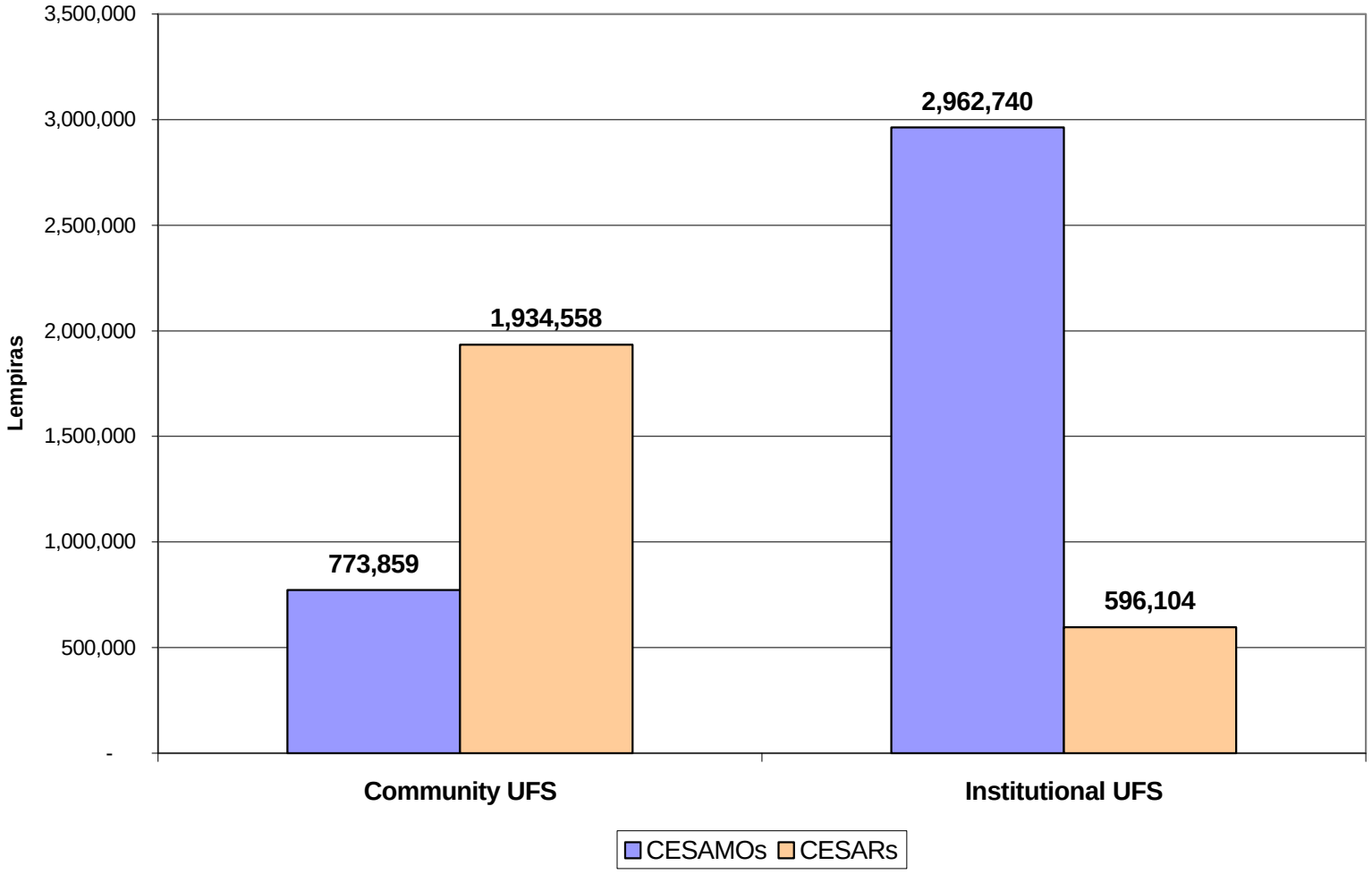
Nor is there data on what has been happening to the average level of revenues produced by a CS. It is likely, that it has followed a course similar to that of the IS--i.e., remaining constant or increasing in nominal terms, but decreasing in real terms—though the CSs have probably fared a bit better because they are growing in number and the more recent established ones have higher fee levels. This is particularly true of the CSs in CESARs, where, in the last two years, 41 percent have increased their fee levels, compared to just 18 percent of the CESAMOs'. It may be that the ISs are being transformed into mixed or community system in order to be able to more easily increase their prices and, thereby, their revenues.

5.4 Taking a Closer Look at the User Fee System Revenues in the Regions

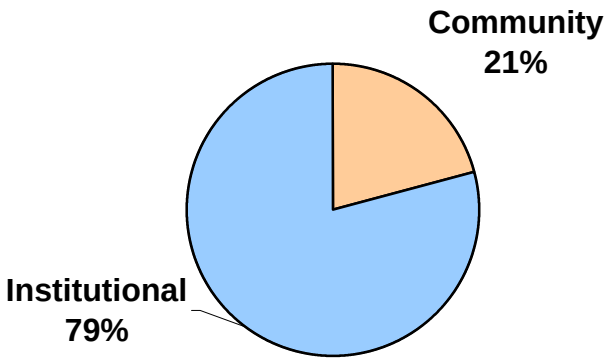
This section analyzes the UFSs in only the CESAMOs and CESARs. Graph 29 presents the 1999 total UF revenues in CESARs and CESAMOs disaggregated by type of UFS. Nationally the ISs generated nearly 3.5 million lempiras, 30 percent more than the CSs' 2.7 million. The CSs generated fewer revenues than the ISs despite the fact that they are far more numerous and have higher prices. The mean price of a CS is 3.08 lempiras compared to 2.00 for ISs (the medians are 3.00 and 2.00, respectively). The smaller yield of the CSs is primarily due to their being overwhelmingly (85 percent) located in CESARs. Community systems are far more important in CESARs, where they account for 76 percent of total UFRs, whereas in CESAMOs the ISs' accounted for about this same proportion, 79 percent. (See Graphs 30 and 31.) In CESAMOs, the 1999 average level of IS revenues per facility was 51 percent greater than that of CS revenues. The ISs' averaged 13,500 lempiras per facility, compared to 8,895 lempiras for CSs.

Even though CESAMOs with CSs have significantly higher prices, the number of consultations they provide is so much smaller that they generate lower total revenues. Table 37 shows the prices, average revenues per paid consultation and total number of consultations provided by facilities with each of the two types of UFSs in CESAMOs, are significantly different.

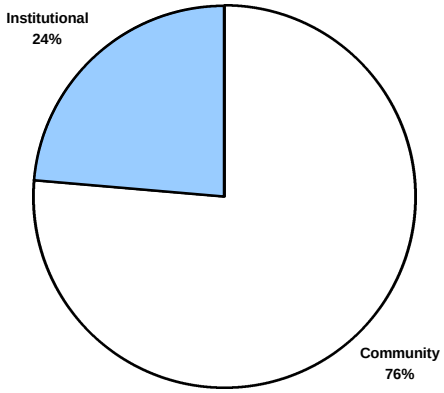
Graph 29: CESAR and CESAMO User Fee Revenues by Type of System, 1999



Graph 30: The UFS Source of CESAMOs' Total User Fee Revenues, 1999



Graph 31: The UFS Source of CESARs' Total User Fee Revenues, 1999



As may be seen in Table 38, compared to CESAMOs among CESARs there are few differences between the three types of user fee systems in terms of their prices, average revenues, number of consultations and total revenues. The only statistically significant differences are the ISs' and CSs' prices, average revenue per consultation and average revenue per paid consultation, all three of which are higher in the community systems. (See Table 38.)

One might conjecture that there is a causal relationship that explains the observed pattern of facilities with relatively high prices having low levels of service delivery and lower revenues; viz., that the higher prices were responsible for the lower revenues because they discouraged utilization. Graph 32 was developed to examine this possibility. The graph plots the total consultations provided at the 121 CESAMOs and CESARs for which there are complete data on consultations (from the MOH AT2 files) and on whether or not they changed the level of their user fees or first established their UFS in the past four years (from the PHR survey). The graph shows that the level of service delivery in these 121 facilities over the five-year period has generally been upward (as shown by the trend line labeled "all"). It grew at rates of eight, two and 19 percent in 1996, 1997 and 1998, respectively and then fell by two percent in 1999. There is some, but little, evidence that is consistent with the stated hypothesis. Depending upon the timing and magnitude of the price change, to the extent that they exist, utilization impacts are most likely to be evident in the same year as the price hike, but they could conceivably occur the subsequent year if they occur late in the year. To the extent that there is some evidence that is consistent with this interpretation it should be noted that the demand for health care is not dependent only on the price of care. Rather, it is multi-factorial. Thus, to the extent that some evidence that is consistent with this interpretation is found, it should still be noted that this does not constitute definitive proof of the impact. With that caveat in mind, we turn to the graph.

The graph plots total consultations for five groups or cohorts of facilities, and for all of the facilities together. There appears to be no utilization impact for two of the cohort of facilities, those that changed their fee levels in 1996 or 1999. Those that modified their systems in 1997 experienced a four percent decrease in the number of consultations provided that year and there was a 3 percent decrease in consultations in 1997 by facilities that introduced modifications in 1998. These reductions are the only two observations that are consistent with the price increase having discouraged utilization. The magnitude of the changes, however, is small and not statistically significant for either of the cohorts.

The "no changes" cohort's utilization maps the same plot as that of all of the facilities considered together; increasing from 1995 to 1998 and then slipping in 1999. With the exception of the 1997 group, all of the cohorts experienced reductions in their service delivery totals in 1999. **In conclusion, there is no evidence that price increases in the user fee levels of CESAMOs and CESARs has dampened utilization, or, by extension, that the CESAMOs and CESARs with higher prices generate lower revenues because they have deterred utilization.** The lower levels of service provision are attributable to other factors; e.g., a smaller catchment area population, a healthier population, few or no alternative sources of care, etc.

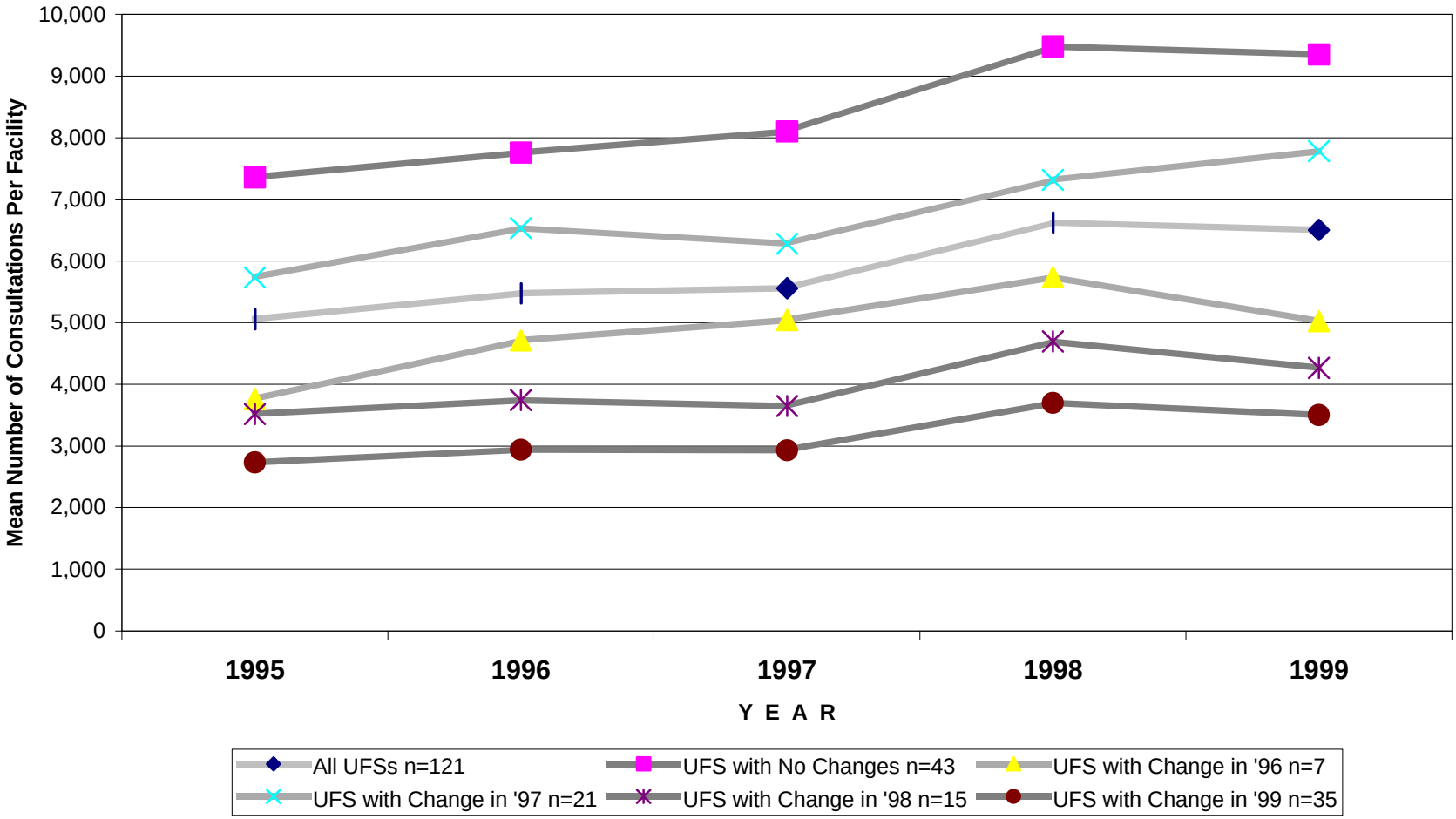
5.4.1 Prices, Revenues and Service Provision Levels by Age of the UFS

The characteristics and performances of the user fee systems of CESAMOs and CESARs were found to vary significantly by the age of the UFS. Four distinct age categories were defined empirically. The four categories—less than three years old, three to five years old, six to ten and

Table 38
Comparing Service Delivery Levels and Revenues of Institutional, Community and Mixed User Fee Systems in CESAMOs

	Institutional UFSs	Community UFSs	Mixed UFSs	Calculated t-Test Value	Statistical Significance
	n=55	n=5	n=10		
Price	1.93	3.40		3.67	99%
Total Consultations	10,232	3,849		4.46	99%
Average Revenue per Consultation-All Types	1.37	1.84		0.95	NS
Average Revenue per Paid Consultation	2.41	4.2		3.7	95%
Total Revenue	13,992	9,149		0.54	NS
Price		3.40	3.40	0	NS
Total Consultations		3,849	6,772	2.693	95%
Average Revenue per Consultation-All Types		1.84	2.81	0.97	NS
Average Revenue per Paid Consultation		4.2	5.43	0.57	NS
Total Revenue		9,149	20,080	1.45	NS
Price	1.93		3.40	4.90	99%
Total Consultations	10,232		6,772	2.47	95%
Average Revenue per Consultation-All Types	1.37		2.81	3.29	99%
Average Revenue per Paid Consultation	2.41		5.43	3.62	99%
Total Revenue	13,992		20,080	1.02	NS

Graph 32: Investigating the Impact of the Introduction of User Fees or An Increase in User Fees in CESAMOs and CESARs: Cohorts of Facilities Defined by the Year Their UFS was Introduced or Modified



more than ten years old--break the facility population into four roughly equal groups. Table 39 shows how UFSs' prices, total revenues, total consultations and average revenue per paid consultation vary significantly by age category. These findings provide further evidence that the age of a UFS is inversely related to its prices. The older UFSs have low fees and have generally never increased them. The newer systems have higher fees. A t-test of the mean number of years since the last fee change found that of UFSs less than 3 years old to be significantly different (though at only the 93 percent level) from that of UFSs more than 10 years old, 1.8 and 3.8 years, respectively (calculated t=1.89).

5.4.2 Explaining Variations in the Total Revenues of CESAMOs and CESARs

A regression was specified to explore sources of variation in the level of total revenues of the CESAMOs and CESARs in 1999. The regression is presented in Table 40. The regression explained 48 percent of the variation in total revenues in 157 facilities, and is statistically significant at the 99 percent confidence level. Only four of the ten independent variables are statistically significant. The vast majority of the explained variation in total revenue is accounted for by the number of total consultations provided by the facility. This variable had an adjusted R square of .394, 81 prcent of the adjusted R square of the entire equation. The next most powerful explanatory variables were the age of the UFS and if the system was a mixed UFS (the reference point was a community system). Both of these variables accounted for an additional four percent of the explained variation in total revenues. The final significant variable was price. Its incremental contribution to explained variation was just 1.3 percent. Total revenues are equal to price multiplied by the number of services provided, net of free care. The small impact of price relative to the number of consultations is due to the very low level of prices. The size of the estimated price coefficient, however, is much larger than that of total consultations, 1413.72 and 1.00, respectively. The coefficient tells by how much total revenues in CESAMOs and CESARs will be increased if the dependent variable is increased by a single unit. That is, if price is increased by 1.00 it will generate an increase in total revenues of 1,413.72 lempiras, and if the number of total consultations is increased by 1.00 it will increase total revenues by 1.00.

Again, the age of the UFS is important, even when the number of consultations provided, price, the type of UFS, the type of facility and the health status of the municipality are controlled for. Again, this likely reflects one or more characteristics of the facility's catchment area that is not otherwise controlled for, or is inadequately controlled for in the equation.[16]

5.4.3 Regional Variations

As Graph 33 shows, the regional composition of the revenues by type of UFSs varies substantially. (These are the weighted sample estimates of all MOH facilities' revenues.) The relative importance of CSs is greatest in Juticalpa, where they constitute 86 percent of the total, and least in Metropolitana, where there are none. Community system revenues average just less than one quarter of total regional user fee revenues.

[16] The health status variable may be too aggregative as it is at the municipality level. An attempt was also made to investigate the significance of another catchment area variable, per capita income. This variable, however, was found to be highly correlated with the health status variable. Their simultaneous inclusion in the equation introduced an unacceptable amount of multicollinearity. The per capita income variable, therefore, was dropped from the analysis.

Table 39
Comparing Service Delivery Levels and Revenues of Institutional, Community and Mixed User Fee Systems in CESARs

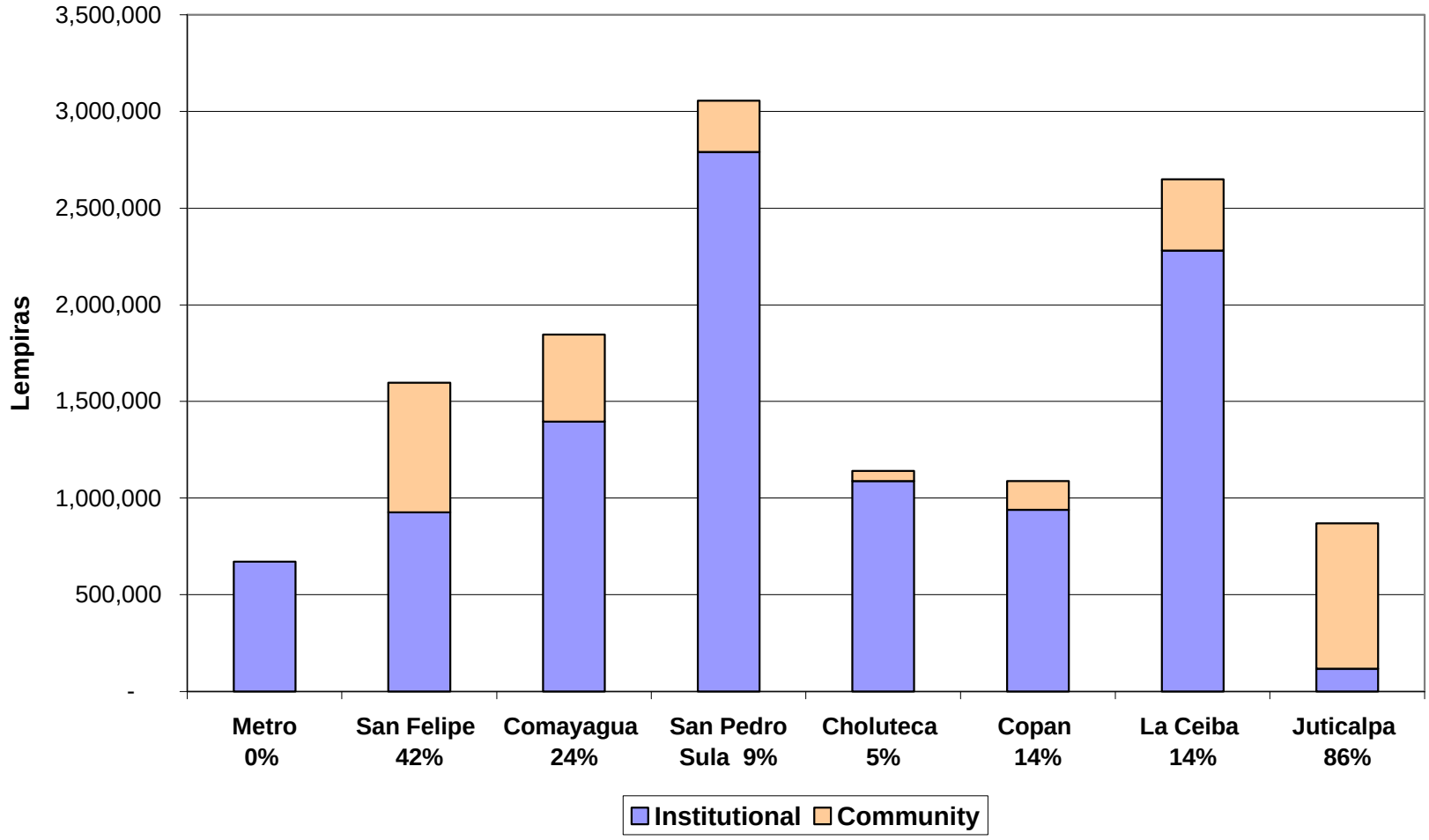
	Institutional UFSs	Community UFSs	Mixed UFSs	Calculated t-Test Value	Statistical Significance
	n=20*	n=60*	n=6		
Price	2.21	3.05		2.50	95%
Total Consultations	2,785	2,399		1.05	NS
Average Revenue per Consultation-All Types	0.82	1.84		3.39	99%
Average Revenue per Paid Consultation	1.41	4.18		2.88	99%
Total Revenue	3,501	4,413		0.81	NS
Price	2.21		2.83	1.25	NS
Total Consultations	2,785		2,858	0.73	NS
Average Revenue per Consultation-All Types	0.82		2.35	0.32	NS
Average Revenue per Paid Consultation	1.41		4.6	0.40	NS
Total Revenue	3,501		7,658	0.10	NS
Price		3.05	2.83	0.38	NS
Total Consultations		2,399	2,858	0.92	NS
Average Revenue per Consultation-All Types		1.84	2.35	0.93	NS
Average Revenue per Paid Consultation		4.18	4.6	0.25	NS
Total Revenue		4,413	7,658	1.83	NS

Table 40
Comparing CESAMOs' and CESARs' User Fee System Revenues
Average (Mean) Measures by the Age of the User Fee System, 1999

Age Category of UFS	Number of UFSs	Price of a General Consultation	Number of Consultations Per Facility	Visits Provided Free-of-Charge	Total Revenues Per Facility	Average Revenue Per Consultation
(1) 2 years or less	39	3.13	2,837	1,148	5,217	1.84
(2) 3 - 5 years	34	2.56	4,289	2,024	5,876	1.37
(3) 6 - 10 years	36	2.54	6,177	2,725	11,218	1.82
(4) More than 10 years	31	1.90	11,268	4,674	17,415	1.55

Student t-tests of the difference between age categories 2 and 3's (i.e., 3-5 years and 6-10 years old) mean prices and of the difference between age categories 1 and 3's average revenues are not significantly different. Student t-tests of the difference between the age categories 1 and 2's mean price is statistically significant at the 90 percent confidence level. For all other variables, the difference between any pair of age categories are statistically significantly different at the 95 percent or greater confidence level.

Graph 33: Total User Fee Revenues by Type of User Fee System and Region, With Community Systems' Revenues as a Percent of the Total



5.5 Institutional User Fee System Expenditures

Graph 34 shows how institutional user fee income was spent in 1999. Purchases of materials and supplies (including medicines) accounted for 57 percent of total expenditures. Non-personnel services was the other major expenditure category. Contrary to what might be expected (given the often heard complaint that medicines are in short supply) expenditures on medicines are relatively small, six percent of the value of total purchases in 1999.

As may be seen in Graph 35, the relative importance of the three general categories of expenditures was the same in each of the four facility types. In all four types of facilities, Materials and Supplies is by far the largest of the three expenditure categories, accounting for between 55 and 74 percent of total expenditures. Non-personnel Services is the next most important category, accounting for between 20 and 43 percent of total expenditures, with the residual comprised of Machinery and Equipment, accounting for only about 5 percent of expenditures.

The largest difference is the relatively larger share of non-personnel services in the regions, where they account for twice their share in the hospitals. It is reported to be common for facilities to report paying for basic services, such as water, electricity and telephone. Apparently institutional user fee revenues are increasingly being relied upon to cover the basic, recurrent operating costs of MOH facilities. By implication, it appears as though the relative funding level of the average MOH facility has been falling in real terms

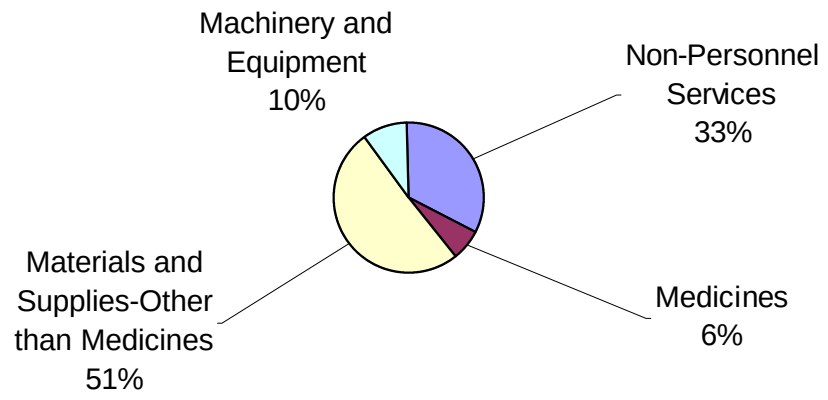
5.5.1 Regional Offices' Expenditures of Their 25 Percent Apportionment of IUF Revenues

The average RO received nearly 129,000 lempiras, and the nine ROs together posted revenues of just less than 1.2 million lempiras. This suggests that total institutional user fee revenues in 1999 were 4.6 million lempiras. This figure is 10 percent less than 5.1 million lempiras the regional offices revenues together reported to the UPEG. In eight of the nine regions, the UPEG-reported total exceeds the amount calculated from the ROs' 25 percent apportionment that interviewees reported in the survey. The reasons for these discrepancies are not known. It is likely that they are due the ROs retaining a smaller fraction than the 25 percent they entitled to according to the Manual.

Graph 36 shows the composition of ROs' expenditures of their apportioned UF revenues in absolute terms and Graph 37 shows their percentage composition. Forty-one percent of the expenditures (446,000 lempiras) are comprised of non-personnel services. The only other categories accounting for more than seven percent of total expenditures are gasoline and per diem. Medicines represent a surprisingly low proportion, 7 percent. (Non-personnel services include a variety of items, including paying for rent, water and electricity.)

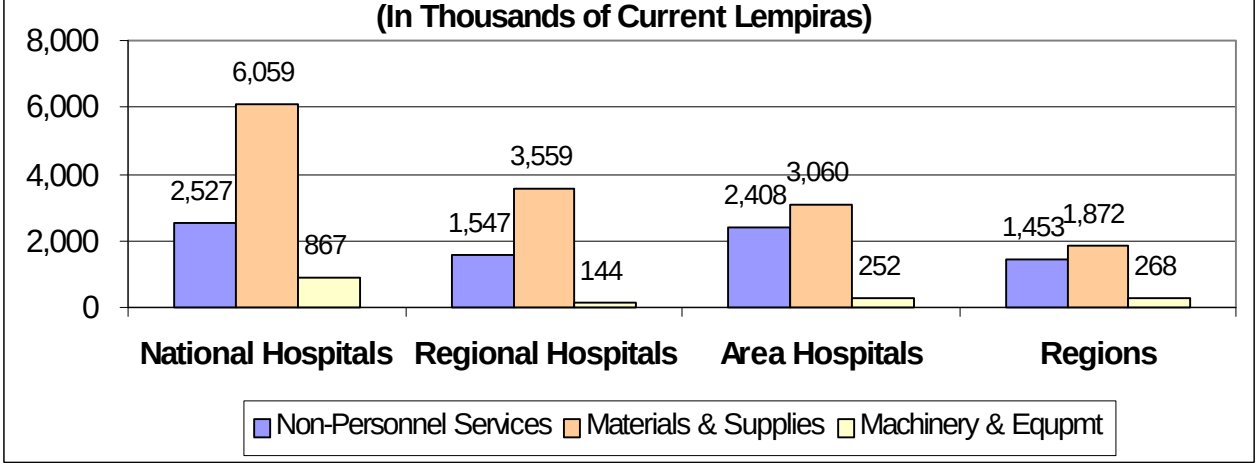
As Graph 38 shows, roughly half of the regional offices' UF revenue-based expenditures were made for the benefit of CESAMOs in their respective regions. The ROs were the beneficiaries of 34 percent, with the remainder destined for CESARs and Area Hospitals. All of the ROs spent some of these funds for the benefit of the regional office, and eight out of nine spent some of these discretionary monies on CESAMOs. Only Copan spent any of these funds for the benefit of an Area Hospital.

Graph 34: Composition of 1999 MOH Institutional User Fee Revenue Expenditures

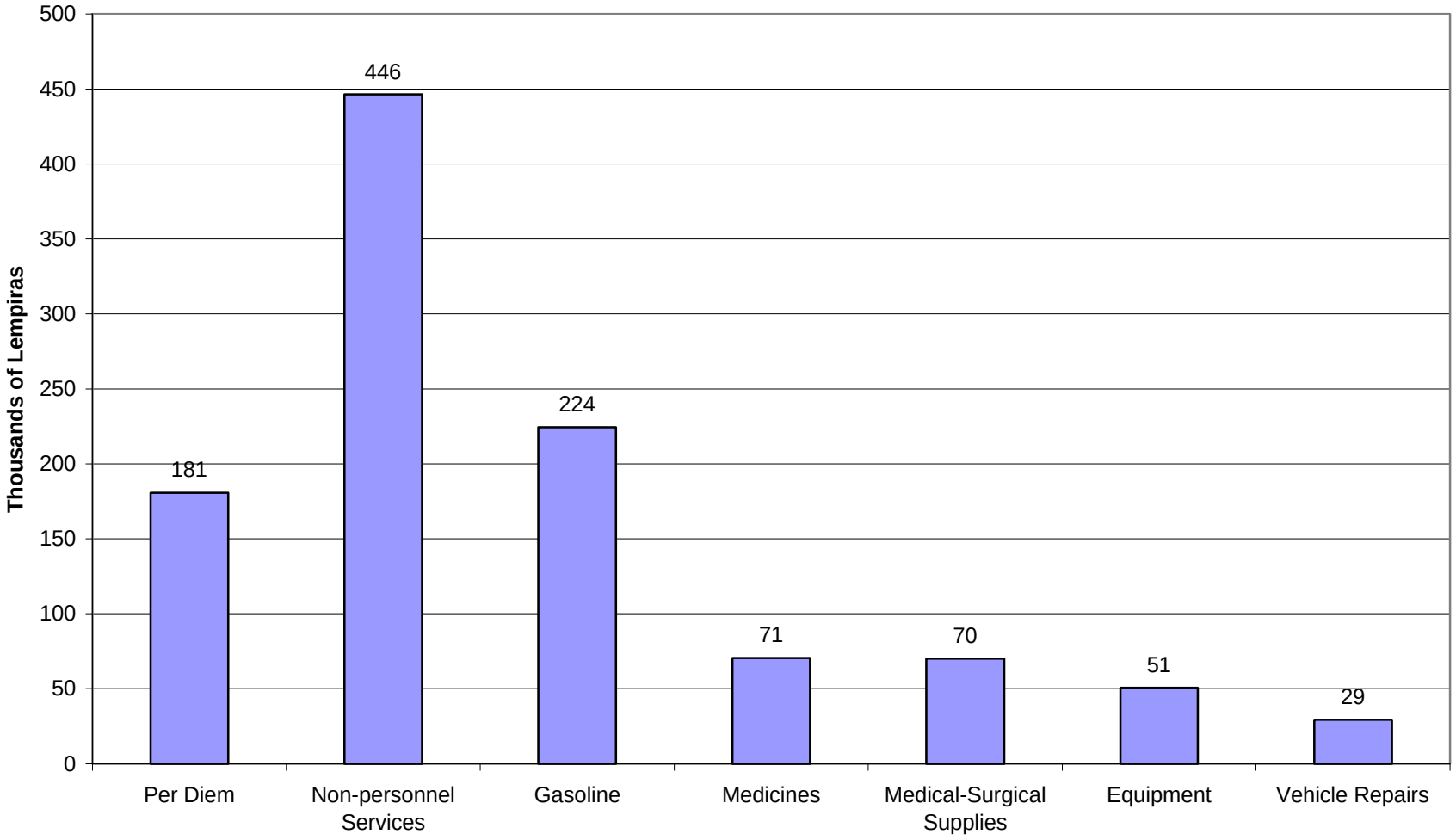


Graph 35: Expenditures of Institutional User Fee Revenues by Type of Item Purchased and Facility, 1999

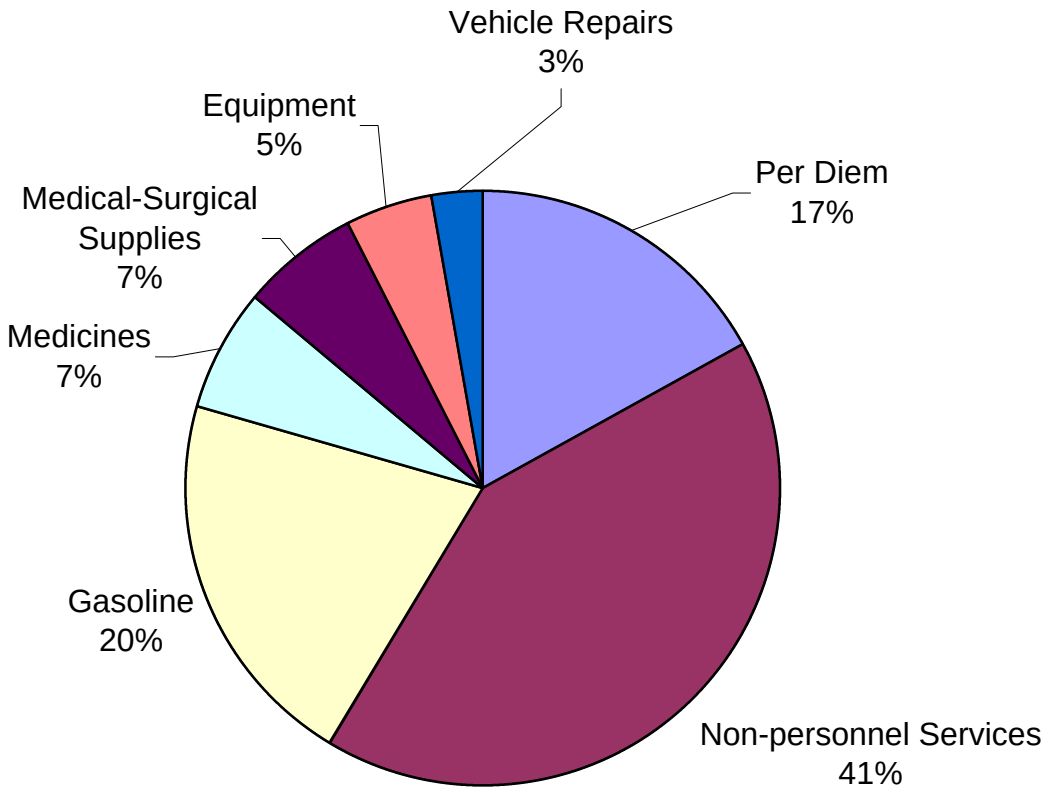
(In Thousands of Current Lempiras)



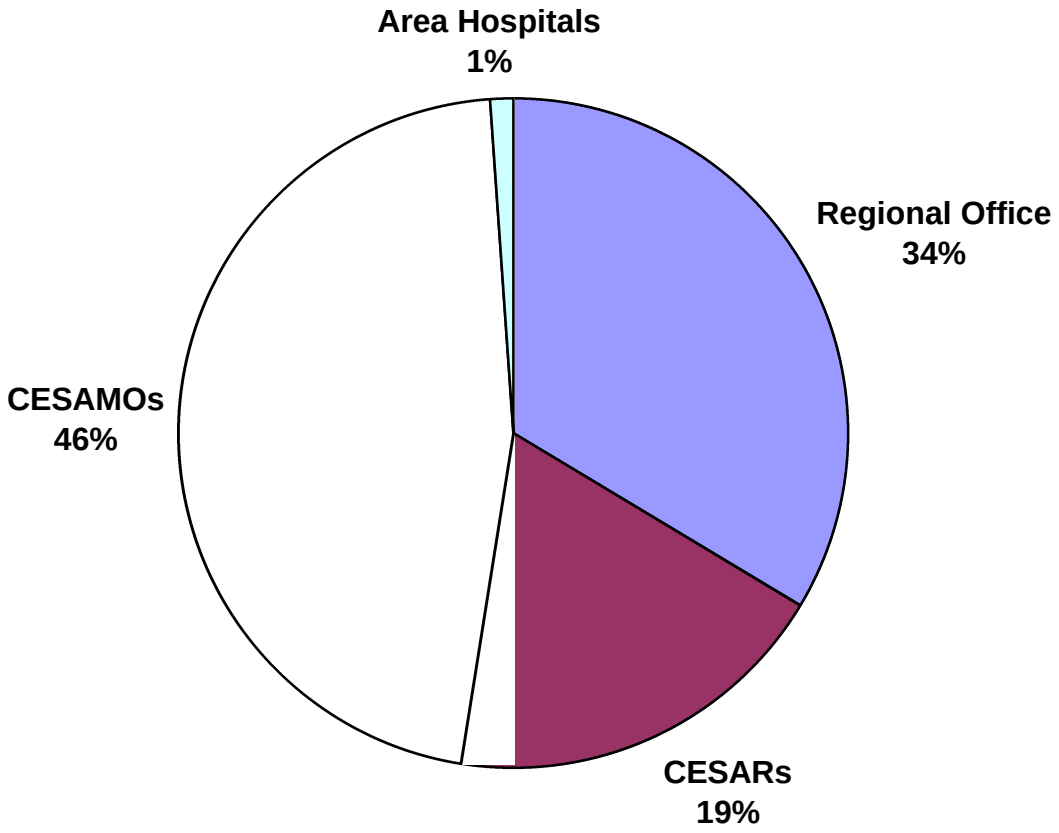
Graph 36: Composition of Regional Office Expenditures of Their 25 Percent Apportionment of Institutional User Fee Revenues, 1999



Graph 37: Composition of Regional Office Expenditures of Their 25 Percent Apportionment of Institutional User Fee Revenues, 1999



Graph 38: Regional Office Expenditures of Their 25 Percent Apportionment of Institutional User Fee Revenues by Type of Facility, 1999



5.6 The Current Account Balances of the Institutional User Fee Systems

The institutional user fee bank balances reported at the time of the interview varied enormously, from zero to more than 2.1 million lempiras. The mean balance was nearly 50,000 lempiras, while the median was zero. Table 42 shows the distribution by type of facility and region. Only hospitals have significant balances. The 62 CESAMOs with institutional user fee systems that were surveyed together had a balance of less than 1,000 lempiras and the 25 CESARs had a balance of zero. 99.9 percent of the regions' balances are comprised of the area hospitals' balances.

Table 43 shows a breakdown of the average balances by type of user fee system, type of facility and region. Seventy-six percent of all institutional systems had a balance of zero. At the opposite extreme, two facilities each had balances of 1.8 million lempiras or more.

The community systems that maintain a bank account are all held by either CESAMOs or CESARs. It is not surprising, therefore, that the size of the bank balances of the community systems are much lower than those of the institutional systems, as the institutional systems accounts are dominated by the hospitals. Ninety-five percent (77) of the 81 community systems' balances are zero. The mean was 76 lempiras and the median was zero.

These balances reflect different things for different UFSs. Some routinely use these accounts and deposit their UF revenues in them regularly. Others use them infrequently due to problems of access. In the case of facilities for which the regional office oversees funds, how much will be in an account at any particular moment will depend on where the particular facility is in the monthly cycle of regional office supervision. If the facility has just handed over to, or had its funds picked up by the regional office staff, its balance would be expected to be low; at most the 2,000 lempiras that it is allowed to retain in its rotating fund. On the other hand, if this interaction with the regional office is to take place in the next few days, to the extent to which the facility uses the bank account, the facility will have the accumulated revenues of the month in its account, and the balance is more likely to exceed the 2,000 lempra limit. Given that the interviews were conducted nearly continuously over a four-month period of time, one would expect to have found facilities at every point in the regional office user fee activity cycle. That the vast majority of balances are uniformly equal to zero is perplexing. Evidently few UFSs routinely use their bank accounts. It may be that these funds are spent as quickly as they are brought in, in which case it would appear that the RFRM regulation that only a rotating fund be spent by the facilities is not enforced. Alternatively, the other extreme may be a more accurate depiction of the situation: it may be that zero balances are evidence of the bottleneck that the RMRF regulation has created.

There is another irregularity concerning the UFS balances. The officially reported monthly revenues and expenditures of the institutional UFSs were analyzed from January 1996 to December 1999. It appears as though the facilities' ISs have been amassing large reserves. Alternatively, it may be that the substantial excess of revenues over officially reported expenditures reflects considerable leakage out of the system. A third possibility is that the bank accounts of the facilities are used only to manage their rotating funds and that all other funds are held by the regional office.

In interviews with MOF personnel who track these financial flows, the MOF staff complained of a number of hospitals, and to a lesser extent regional offices, that routinely submit their financial reports tardy and only after considerable haggling. **In conclusion, even the institutional systems that are subject to regional office and central government oversight activities, the UFSs lack transparency.**

Table 42
Current Bank Account Balances of the User Fee Systems

Unweighted Sample Results, Expressed in Lempiras

Characteristic	*Institutional Systems*		*Community Systems*	
	No. of Facilities	**Total Balance**	**No. of Facilities**	**Total Balance**
Type of Facility				
National Hospital	6	4,448,418		
Regional Hospital	6	426,708		
Area Hospital	16	782,610		
All Hospitals	28	5,657,736		
CESAMOs	62	992	15	1,770
CESARs	25	-	66	4,356
Region*				
Metropolitana	3	999		-
San Felipe	10	236,440	22	1,760
Comayagua	12	32,400	12	228
San Pedro Sula	17	308,567	9	-
Choluteca	28	20,664	4	-
Copan	15	43,620	2	3,230
La Ceiba	13	140,400	13	-
Juticalpa	3	-	19	912
Puerto Lempira	1	500		-
All Regions	102	783,564	81	6,130
All Facilities	**114**	**5,658,734**	**81**	**6,130**

Table 43
Bank Account Current Balance
in Institutional and Community User Fee Systems
(Unweighted Sample Data)

	Institutional User Fee Systems				*Community User Fee Systems*			
Characteristic	**Number of Respodents**	**Number With a Balance of Zero**	**Mean**	**Median**	**Number of Respodents**	**Number With a Balance of Zero**	**Mean**	**Median**
Type of Facility								
National Hospital	6	0	741,403	156,299				
Regional Hospital	6	0	71,118	47,903				
Area Hospital	15	1	52,174	20,946				
All Hospitals	27	1						
CESAMOs	62	61	16	0	15	14	118	0
CESARs	25	25	0	0	66	63	66	0
Region*								
Metropolitana	3	2	333	0				
San Felipe	10	9	23,644	0	22	21	80	0
Comayagua	12	10	2,700	0	12	11	19	0
San Pedro Sula	17	13	18,151	0	9	9	0	0
Choluteca	28	27	738	0	4	4	0	0
Copan	15	13	2,908	0	2	1	1,615	1,615
La Ceiba	13	10	10,800	0	13	13	0	0
Juticalpa	3	3	0	0	19	18	48	0
Puerto Lempira	1	0	500	500				
All Regions	102	87	7,682	0	81	77	75	0
All Facilities	114	87 76%	49,638	0	81	77 95%	76	0

NOTE: If two outliers are removed excluded from the All Regions' calculations the mean falls to 2,975 for ISs.

5.7 The Costs of Administering the Institutional User Fee Systems

Cost estimates of the community UFSs were not developed. The variety of structures and different documentation and information systems that characterize these systems dissuaded the Study Committee from pursuing this line of investigation. Only the administrative costs of the institutional UFSs are examined, and the analysis of these is not complete. The development of complete cost estimates would have been too time-consuming and would have made the survey too cumbersome and disruptive to the activities of facility staff. Notwithstanding, as the reader shall see, the estimates developed here are telling.

A few comments on how the costs were estimated is in order. First, the cost estimates presented here include the value of the time of the personnel who administer the systems. The personnel costs include the value of the time of the persons who collect the user fees. Where these individuals were identified in the survey as UFS cashiers or as persons paid by the health committee, they are assumed to devote all of their time to administering the UFS. If the persons collecting fees are other types of personnel, they were assumed to devote only a proportion of their time to administering the system, and thus only a portion of their salaries were included in the cost estimates. In hospitals it was assumed that in addition to full-time cashiers that an accounting assistant and a social worker also devote full-time to UFS operations. It was assumed that the persons who collect the fees in CESAMOs, devote a total of 75 percent of their time to all UFS-related matters, and that in CESARs the fee collectors dedicate 20 percent of their time to UF operations (fee collection, determination of ability to pay, receipt writing, completing ledgers and regional office reporting forms, etc.).

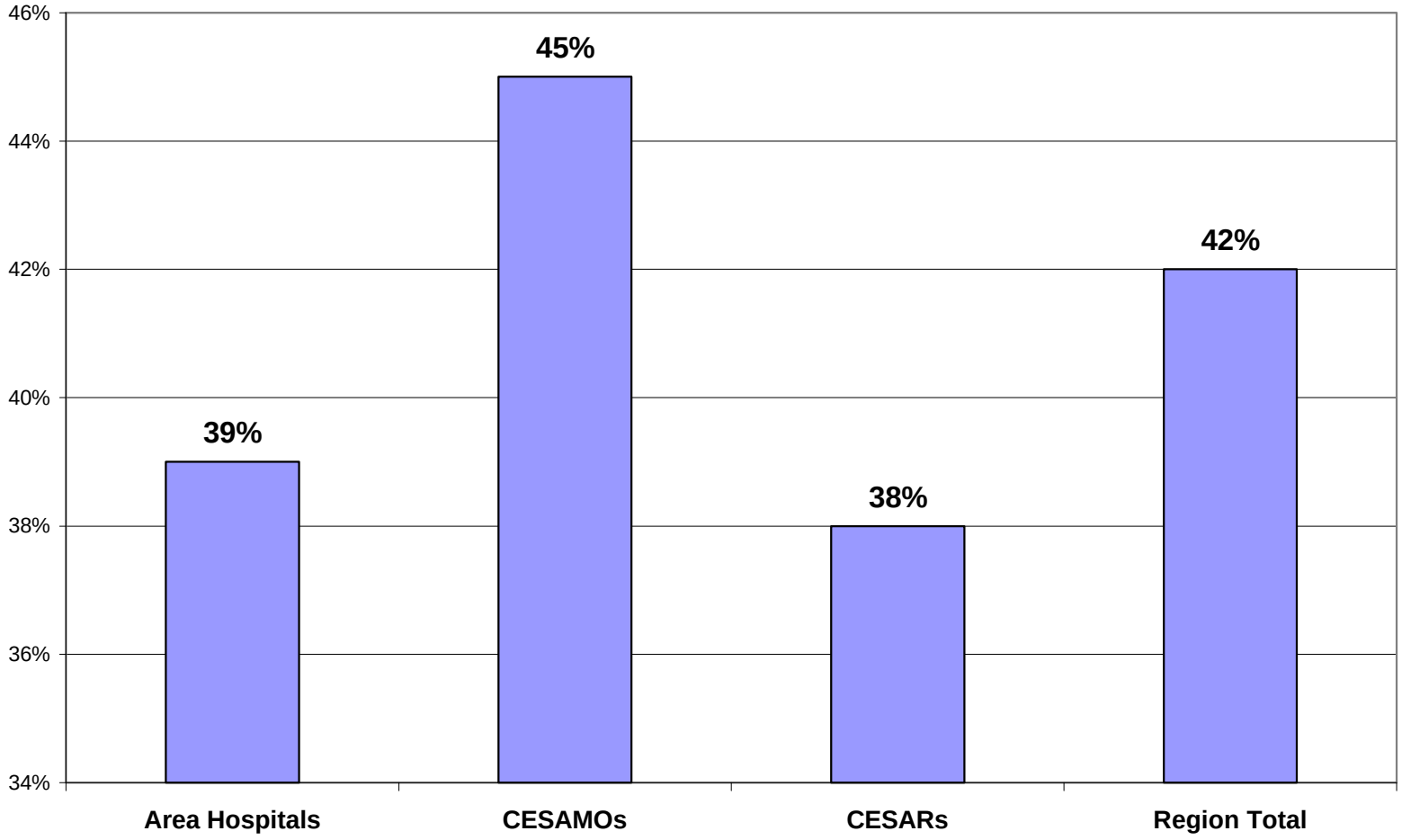
Second, it should be noted that there are also costs incurred in using, that is spending, the user fee revenues. Those costs are not included in the cost estimates presented here. The focus here, instead, is exclusively on the administrative cost burden. Third, the costs of the time of other persons in CESAMOs and hospitals who are involved in other aspects of the administration and operations of the user fee systems, such as in CESAMOs the determination of ability to pay, and in both CESAMOs and hospitals, the reviewing of ledgers and reporting forms by the facility director and/or administrator, among other activities, are not included here. Fourth, the cost of materials—pens, pencils, paper, calculators, adding machines, ledgers, etc.—used in the administration of the systems is not calculated. Fifth, the opportunity cost of the time of volunteer staff who collect fees was not valuated. Sixth, the cost of making home visits, which 19 percent of the surveyed facilities reported they do to determine a patient's ability to pay, is not included.

The result of these various simplifying assumptions is that the full costs of administering the IUFSs are under-estimated, though the proportion by which they are is not thought to be great. The estimates here probably account for between 75 and 90 percent of the total costs. It was decided that the cost required to achieve added precision was not justified. We now turn to a discussion of the components of the administrative costs of the institutional UFSs.

5.7.1 The Cost of an Official Receipt versus the Price of a Consultation

As already noted, the cost of an official MOF booklet of 50 receipts is 40 lempiras. Graph 39 shows the cost of a receipt as a percent of the general consultation fee. It varies from a near equivalent of just less than 40 percent in the higher average priced area hospitals and CESARs, to 45 percent in the typical CESAMO. Averaged over all three types of regional office facilities, the cost of

Graph 39: The Cost of a Receipt as a Percent of the General Consultation Fee



a receipt is equal to 42 percent of a general consultation fee. This cost constitutes a significant proportion of IUFS revenues.

The standard practice is not to issue a receipt when services are provided free-of-charge. This practice is understandable given the relatively high cost of receipts, but it facilitates compromising the integrity of the system. Requiring that all persons receiving service be given a receipt, would discourage the common complaint heard in many facilities, that the granting of exemptions is arbitrary and excessive. If this practice were adopted, however, given the relatively high cost of receipts it might mean that the net revenues generated by the system would be even lower (depending upon the proportion of unwarranted exemptions that would be eliminated). If so, to maintain the net income generation in such facilities, it would be necessary to raise fees at the same time that this practice was implemented.

To estimate the total cost of receipts used in the IUFS in 1999 we first multiplied the number of services for which fees are charged by the cost of a receipt. This, however, overstates the cost, as a proportion of those services are provided free-of-charge because of the category of the patient (i.e., because the patient is medically indigent, a community health person, etc.). As already noted the survey did not collect information about the number of such exemptions provided. For an estimate of this proportion, we turned to the ENIGH survey. We multiplied the number of services for which fees are charged by the cost of the receipt by the facility type-specific estimates of the proportion of persons who reported in the ENIGH that they paid for their care. The total cost of receipts for the entire institutional UFS in 1999 was 1.3 million lempiras.

5.7.2 Estimating the Facility Personnel Costs of UFS Administration

As already noted, in the 186 facilities in the sample, there are 58 cashiers. The mean value of the limited number of observations for which there was data about the cashiers' monthly salaries was 2,662 lempiras. It was assumed that the 16 health board paid employees received this salary as well and dedicated all of their time to administering the UFS. The sample weights were used to extrapolate the proportion of facilities with cashiers or health committee-paid staff to the remainder of MOH facilities. For the remainder of facilities without cashiers the personnel costs of administering the IS was estimated by assuming that in CESAMOs that a nurse auxiliary spent 75 percent of her time devoted to the UFS and in CESARs 20 percent. The estimated costs of the fee collectors in MOH facilities throughout the country are presented in Table 44. The top portion of the table includes all fee collectors regardless of who pays them. These costs total 15.4 million lempiras annual. The bottom portion of the table includes only those collectors who are paid by the MOH. These costs annual total 11.1 million lempiras. It should be recognized that for the 72 percent of MOH-financed positions which are not cashiers that the cost of these salaries are not additional direct outlays that the MOH pays in order to operate these systems. Rather, these are the opportunity costs of persons who are already paid staff who are devoting a proportion of their time that would otherwise be spent providing or assisting in the provision of patient care. It is assumed that in each MOH hospital that one assistant accountant and a social worker are dedicated full-time to maintaining the UF ledgers and assessing patients' ability to pay and are paid 4,000 and 3,000 lempiras monthly, respectively. Adding in the 3.26 million lempira annual cost of these positions, gives us an MOH total in-facility institutional UFS administrative cost of 14.36 million and a total IUFS administrative cost (regardless of the source of financing) of 18.66 million lempiras.

Table 44
The Personnel Cost of User Fee Collectors by Type of Facility
All Types of User Fee Systems, All Sources of Financing

	Paid Worker				Average Annual	Total Annual Cost of Collector			
	Hospitals	CESAMOs	CESARs	Total	Salary	Hospitals	CESAMOs	CESARs	Total
A. All Sources of Financing									
UF Cashier	28	89	18	135	43,915	1,229,620	2,931,326	158,094	4,319,040
Nurse Auxiliary		135	385	520	58,408		5,913,810	3,381,455	9,295,265
Health Board		8	49	57	43,915		263,490	430,367	693,857
Medical Record Assistant		3	3	6	43,915		98,809	26,349	125,158
General Assistant			45	45	43,915			395,235	395,235
Director or Administrator		5		5	106,560		399,600		399,600
Physician		2		2	106,560		159,840		159,840
Total:	28	242	500	770		1,229,620	9,766,875	4,391,500	15,387,995
B. MOH-Financed Only									
UF Cashier	28	83		111	43,915	1,229,620	2,733,709		3,963,329
Nurse Auxiliary		120	156	276	58,408		5,256,720	1,370,148	6,626,868
Health Board					43,915				
Medical Record Assistant		3	3	6	43,915		98,809	26,349	125,158
General Assistant					43,915				
Director or Administrator		3		3	106,560		239,760		239,760
Physician		2		2	106,560		159,840		159,840
Total:	28	211	159	398		1,229,620	8,488,838	1,396,497	11,114,955

Average annual salaries of UF cashiers are calculated from survey data. No information was collected on the pay of persons who are paid by the community health boards. It was assumed that they received the same salary as a UF cashier, most of whom are paid MOH staff.

Assumes: UF Cashiers and Health Board employees work 100 percent of time as fee collector/cashier, and all other personnel who collect fees and work in CESAMOs spend 75 percent of their time managing the UFS and in CESARs they are assumed to spend 20 percent of their time managing the UFS.

It is assumed that in each hospital an assistant accountant devotes full-time to maintaining the UF books and a social worker dedicates his/her full-time to assessing patients' ability to pay, and their average monthly salaries of these positions are 4,000 and 3,000 lempiras, respectively. The additional annual cost of these positions is 3.26 million lempiras for all 28 hospitals and is wholly paid by the MOH.

5.7.3 Regional Office Monitoring and Supervision Costs

According to regional office respondents there are 40 different persons in the 9 ROs that help to administer the institutional user fee systems. These persons, on average, work about half-time on the UF systems. In the nine ROs, administration of the ISs involves 19.5 full-time equivalent staff, as may be seen in Table 45.

The staff administering user fee systems varies across the ROs. Only six of them have a Funds Administrator. Nearly all of the Funds Administrators spend all of their time carrying out the duties related to the institutional UFSs. In all nine ROs an accounting assistant helps in administering the systems and, on average, they spend about 65 percent of their time doing so. Most RO administrators devote about one-third of their total time to administering these systems. The personnel costs of administering the systems is nearly 850,000 lempiras annually. Table 46 disaggregates personnel costs by region. The costs of Health Region 1, San Felipe, alone account for 25 percent of the 9 ROs total personnel costs. Just three ROs account for a disproportionate amount (55 percent) of the total personnel costs.

As already noted, in several regions, RO personnel travel to facilities to pick up UF revenues, or facility personnel travel to their regional offices to submit these monies. These arrangements incur direct costs of transportation and in some instances travel per diems are paid. In addition, and probably more importantly, there are the indirect costs of the staff-time spent, and the opportunity cost of the staff-time. For CESARs, this is the time the facility is closed and patients cannot obtain care because the single staff-person, the nurse auxiliary, is traveling to the regional office to deposit the facility's revenues. In the case of CESAMOs, the opportunity costs are probably not as great. The larger and more specialized staff of the CESAMO, means that while a staff person is traveling to the regional office to deposit the facility's user fee revenues, the facility can remain open and care remains available. Still, the regular duties of the staff-person are interrupted.

With the intent of quantifying the direct and indirect costs of this system, the questionnaire contained questions about the number of personnel, the travel time and the costs of travel to regional offices for this purpose, that were asked of the respondents of the 32 facilities that were reported to take their revenues to the regional office. Respondents for 12 of these 32 facilities, reported either that there was no clearly established system for doing so, or that they did not know the system. Thus there is data for only 20 facilities. Table 47 presents the total annual costs of these 20 facilities. Generally, the staff-persons that do the traveling are nurse auxiliaries (42 percent) or the user fee system cashier (21 percent), suggesting the opportunity cost of this activity is not high in terms of foregone care. This is not uniformly the case, however. In some instances it was reported that physicians, the director of the facility or the facility administrator are the persons involved.

There is no sound method available by which to generalize these results beyond the sample to the entire MOH system. Nevertheless, it was deemed important to develop an estimate, however crude, in order to obtain some idea of how much this activity might cost the system. Accordingly it was assumed that the weighting scheme (which was developed for another purpose—developing total revenue estimates) could be used to develop national level estimates. The weighting scheme was adjusted for the non-response of 12 of the 32 facilities mentioned earlier. As shown in the far right-hand column of Table 47, it is estimated that roughly 625,000 lempiras are spent each year in this activity.

Table 45
Annual Regional Office Personnel Cost of Administering the Institutional User Fee System by Type of Personnel

Type of Personnel / Position	Number of Persons	Number of FTEs*	Personnel Cost**
Administrador	11	3.8	184,564
Asistente de Contabilidad	9	5.7	221,436
Director	6	0.5	60,173
Sub.Director	1	0.1	3,861
Contador	4	1.8	59,300
Receptor de Fondos	6	5.6	248,390
Secretaria	1	1.0	44,064
Conserje	2	1.0	24,480
Total:	40	19.5	846,268

*FTE: Full-Time Equivalents
**Algorithms for calculating annual personnel cost from monthly salary:
Regions 0 and 3: ((monthly salary*1.18*12)+(monthly salary*3))
All other Regions: ((monthly salary*1.11*12)+(monthly salary*3))
12 months + vacation plus aguinaldo plus decimocuarto= 15 monthly salaries
11% INJUPEMP: Instituto Nacional Jubilaciones y Pensiones de Empleados Publicos
7% paid only in Regions 0 and 3 is IHSS contribution of Government as employer.
INJUPEMP and IHSS contributions are paid only on 12 monthly salaries.

Table 46
Annual Regional Office Personnel Cost of Administering the Institutional User Fee System

Health Region		Working on the Institutional User Fee System		Personnel Cost**	Percent of Total Regional Office Personnel Cost
		No. of Persons	No. of FTEs*		
0	Metropolitana	6	3.1	111,356	13%
1	San Felipe	6	4.2	210,400	25%
2	Comayagua	6	3.3	140,352	17%
3	San Pedro Sula	5	1.9	54,102	6%
4	Choluteca	3	1.1	56,187	7%
5	Copan	4	0.9	44,092	5%
6	La Ceiba	3	1.4	72,885	9%
7	Juticalpa	2	1.1	61,749	7%
8	Puerto Lempira	5	2.5	95,146	11%
	Total:	40	19.5	846,268	100%

*FTE: Full-Time Equivalents
**Algorithms for calculating annual personnel cost from monthly salary:
Regions 0 and 3: ((monthly salary*1.18*12)+(monthly salary*3))
All other Regions: ((monthly salary*1.11*12)+(monthly salary*3))
12 months + vacation plus aguinaldo plus decimocuarto= 15 monthly salaries
11% INJUPEMP: Instituto Nacional Jubilaciones y Pensiones de Empleados Publicos
7% paid only in Regions 0 and 3 is IHSS contribution of Government as employer.
INJUPEMP and IHSS contributions are paid only on 12 monthly salaries.

Table 47
Estimated Costs of Facilities Traveling to Their Regional Office to Submit Their Institutional User Fee Revenues

	Sample-Based Estimate	Nation-wide Estimate (Adjusted Weighted Sample)
Number of Facilities	20	142
Average Monthly Travel Time (all facilities)	100.5 hours	885.3 hours
Value of Staff Time Spent Traveling	4,421 lempiras	38,543 lempiras
Monthly Travel Cost (all facilities)	657 lempiras	4,308 lempiras
Average Time per Month at Regional Office* (all facilities)	33 hours	213 hours
Value of Staff Time Spent at Regional Office (all facilities)	1,535 lempiras	9,210 lempiras
Total Monthly Cost	6,613 lempiras	52,063 lemiras
Total Annual Cost	79,356 lempiras	624,753 lempiras

The regional office questionnaire also collected information about these travel-related administrative costs. These consisted of per diem payments and transportation costs, annually costing about 380,000 and 260,000 lempiras, respectively. Table 48 shows the composition the ROs' total annual costs of 1.5 million lempiras to administer the institutional user fee systems. As may be seen in the lower portion of Table 48, personnel costs are the largest component of these cost categories, constituting 57 percent of total RO user fee administrative costs. The components of transportation-related costs, per diem and transportation costs, represent 26 and 17 percent of total costs, respectively.

The Metropolitan Region visits all of its UPSs in the course of administering the UFS. It is the only one that does so, though obviously it is not as difficult a task for this urban-based RO as it would be for the others. At the other extreme, are Choluteca and La Ceiba, which do not visit any UPSs as part of their UFS administrative activities. Health Regions 1 and 3, San Felipe and San Pedro Sula, visit 8 and 6 health areas, respectively. With transportation-related costs zero and having among the smallest number of FTEs administering their systems, Choluteca and La Ceiba have by far the lowest costs.

5.7.4 Central Government IUFS Monitoring and Supervision

As already described, the financial reports from the regional offices and hospitals are sent each month to the MOH's Department of Administration and the UPEG, as well as to the MOF's Office of the General Accountant. In the MOH's Department of Administration one staff-person devotes 50 percent of her time to reviewing and processing these reports. The UPEG staff-person devotes 25 percent of her time to this activity, while the MOF employee devotes all of her time to it. These central level personnel costs total 165,000 lempiras annually. Since these administrative costs include time spent on the hospitals and their inpatient care too, they need to be pro-rated. This was done by assuming that the time required to process each administrative unit was equal (nine regions, six national and six regional hospitals). This yields an estimate of 43 percent of the total staff-time being attributable to the regional office facilities (=9/21), with the residual being the share "spent" on the national and regional hospitals.

5.7.5 Total Administrative Costs of the Institutional UFSs

In Table 49 five components are summed to provide an estimate of the total costs of administering the IS. The total administrative costs of the institutional user fee system in 1999 were 23 million lempiras. The MOH paid the 81 percent of these costs, 18.7 million lempiras.

These estimates include the total in-facility labor costs of operating the ISs. As has already been discussed, in most of the CESARs the individual collecting user fee payments and administering the entire system is usually a nurse auxiliary who is also the only care provider in the facility. The time she spends administering the IUFS reduces the time available for her to see patients. This situation also exists in 61 percent of the CESAMOs with IUFs, as well. The time that a nurse auxiliary (and other staff) spends administering the IUFS is a cost, because it entails the use of a resource, labor. For that reason, and in order to underscore the existence of the tradeoff between administering the IUFS and providing patient care, as well as to calculate the amount of money that would be required to pay cashiers should a decision be made to introduce independent management of the systems, the value of the time that nurse auxiliaries spend administering these systems is included

Table 48
Annual Regional Office Cost
of Administering the Institutional User Fee System

Health Region		Per Diem Cost	Transporta-tion Cost*	Personnel Cost**	Total Cost	Percent of Total Regional Office Admin. Cost
Lempiras						
0	Metropolitana	5,400	4,646	111,356	121,402	8%
1	San Felipe	15,348	33,454	210,400	259,202	17%
2	Comayagua	17,160	15,043	140,352	172,555	12%
3	San Pedro Sula	23,856	27,007	54,102	104,965	7%
4	Choluteca	0	0	56,187	56,187	4%
5	Copan	101,184	103,963	44,092	249,239	17%
6	La Ceiba	0	0	72,885	72,885	5%
7	Juticalpa	25,200	17,424	61,749	104,373	7%
8	Puerto Lempira	191,301	57,790	95,146	344,236	23%
	Total:	379,449	259,327	846,268	1,485,044	100%

Health Region		Per Diem Cost	Transporta-tion Cost*	Personnel Cost**	Total Cost	Number of UPSs or Areas Visited
Percent						
0	Metropolitana	4%	4%	92%	100%	All UPSs
1	San Felipe	6%	13%	81%	100%	8 Areas
2	Comayagua	10%	9%	81%	100%	5 UPSs
3	San Pedro Sula	23%	26%	52%	100%	6 Areas
4	Choluteca	0%	0%	100%	100%	0
5	Copan	41%	42%	18%	100%	12 UPSs
6	La Ceiba	0%	0%	100%	100%	0
7	Juticalpa	24%	17%	59%	100%	1 UPS
8	Puerto Lempira	56%	17%	28%	100%	10 UPSs
	Total:	26%	17%	57%	100%	

*Based on Ministry of Public Works, Transport and Housing's Generate Directorate of Transport Septe
cost estimate for a medium-sized vehicle traveling 50 percent of the time on paved roads and 50 pe
increased by 28 percent to capture the cost increase in gasoline from September to December 199
**Algorithms for calculating annual personnel cost from monthly salary:
Regions 0 and 3: ((monthly salary*1.18*12)+(monthly salary*3))
All other Regions: ((monthly salary*1.11*12)+(monthly salary*3))
12 months + vacation plus aguinaldo plus decimocuarto= 15 monthly salaries
11% INJUPEMP: Instituto Nacional Jubilaciones y Pensiones de Empleados Publicos
7% paid only in Regions 0 and 3 is IHSS contribution of Government as employer.
INJUPEMP and IHSS contributions are paid only on 12 monthly salaries.

Table 49
Administrative Costs of the Institutional User Fee System and Net Revenues Generated in 1999
(In Lempiras)

Cost Element	Annual Cost
Within Facility Labor Cost (regardless of source of financing)	18,652,000
Within Facility Labor Cost paid by the MOH	14,380,000
Central Government Cost	165,000
UPSs' Travel to Regional Office to Deposit Revenues	624,753
Regional Office Administration	1,485,044
Cost of Receipts	2,033,000
Total Cost -- All sources of financing	**22,959,797**
Total Cost -- Only MOH-financed	**18,687,797**
Total Cost -- Only MOH-financed, additional direct outlays:	**11,463,711**
Revenues:	**34,106,933**

Administrative costs as a percent of the total IUFS revenues	
A. All Sources of Financing	67%
B. Only MOH Financed	55%
C. Only MOH Financed, Additional Direct Outlays*	34%

Net revenues of the institutional UFSs	
A. All Sources of Financing	11,147,136
B. Only MOH Financed	15,419,136
C. Only MOH Financed, Additional Direct Outlays*	22,643,222

in the cost estimates.[17] If only the additional direct outlays that the MOH had to pay in order to operate the ISs are included, the total cost of the IUFS in 1999 was 14.3 million lempiras.

Graph 40 shows the composition of the administrative costs of the IUFS. They are comprised overwhelmingly (81 percent) of within-facility personnel costs. While the average level of costs varies dramatically by type of facility, the proportion of total costs comprised of within-facility personnel costs does not. It varies from a low of 75 percent of national and regional hospitals to a high of 86 percent in CESARs.

5.8 Net Income Generation of the Institutional UFS

IUFSs' administrative costs are high. They are the equivalent of two-thirds (67 percent) of their revenues. Tables 50 and 51 present disaggregations of the total IUFS costs, revenues and net revenue data presented in Table 49. Table 50 contains the regions' data, broken down by CESARs, CESAMOs, area hospitals and the regional totals. Table 51 contains the same information for the national and regional hospitals. When IUFS costs as a percent of their revenues are analyzed by type of facility, it can be seen that the magnitude of the cost burden of the systems varies dramatically; from a low of 12 percent in national and regional hospitals, to 45 percent in area hospitals and to an astonishing 332 percent in CESAMOs and CESARs. For each lempira that is generated by the IS, in CESAMOs and CESARs, 3.32 lempiras are spent to administer the system. For the regions as a whole, administrative costs are 166 percent of their revenues. That is, for every 1.00 lempira in revenues the RO systems bring in, 1.66 lempiras are spent. Clearly, if the purpose of the IUFS is to contribute to cost recovery, it is doing a poor job in the regions, and particularly in the CESARs and CESAMOs. Elimination of the IUFS would actually save the MOH money and/or enable its facilities to provide more care.

Another measure of the burden of the administrative costs of the IUFS is the net revenues they generate; i.e., the income they generate is equal to revenues after subtracting costs. (Revenues before subtracting costs are referred to as gross revenues.) Tables 49 through 51 present this indicator for each the different subsets of MOH facilities. The net revenues of the all of the MOH's IUFSs in 1999 were 11.1 million lempiras. They ranged from the national and regional hospitals 19.3 million, to the area hospitals 3.9 million and the CESAMOs' and CESARs' negative 12 million lempiras. The sum of the net revenues of the area hospitals, CESAMOs and CESARs was a negative 8.1 million lempiras.

[17] In the author's judgment, this is the appropriate approach. Some analysts may take exception with this approach, arguing that if these facilities are not operating at full capacity, that there may be no tradeoff between IUFS administration and patient care. In that case, one could argue that the auxiliary nurse's salary is a fixed cost (i.e., it is already being paid regardless of whether or not there is an IUFS) and should not be considered a cost of operating the UFS. The nurse auxiliaries is already being paid by the MOH to provide care, and her administration of the IUFS does not require any additional direct outlays or costs to be incurred by the Ministry. For that reason and because for MOH management purposes, only additional direct outlays may be of interest, the total costs, included only MOH-financed, additional direct outlays are presented.

Graph 40: Composition of the Administrative Costs of the Institutional User Fee System

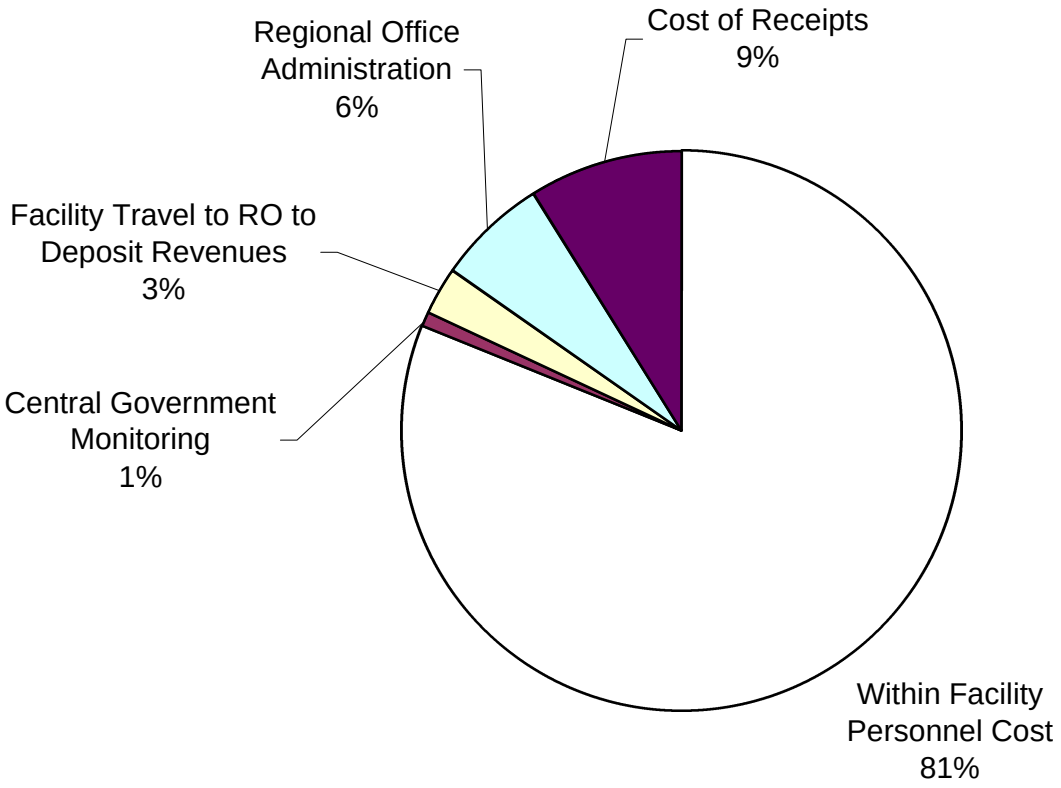


Table 50
Administrative Costs of the Regions' Institutional User Fee System and Net Revenues Generated in 1999

Includes Only Area Hospitals, CESAMOs and CESARs
(In Lempiras)

Cost Element	Regional Total	Area Hospitals	CESAMOs	CESARs	CESAMOs + CESARs
Number of Facilities with Institutional UFSs	442	16	234	192	426
`	16,711,015	2,552,640	9,766,875	4,391,500	14,158,375
Within Facility Labor Cost paid by the MOH	12,510,435	2,552,640	8,488,838	1,468,957	9,957,795
Within Facility Labor Cost - only additional MOH direct outlays*	5,286,349	2,552,640	2,733,709	-	2,733,709
Central Government Cost	70,950	23,650	23,650	23,650	47,300
UPSs' Travel to Regional Office to Deposit Revenues	624,753	6,872	459,193	151,815	611,008
Regional Office Administration	1,485,044	361,838	881,980	241,225	1,123,206
Cost of Receipts	1,482,961	246,693	935,893	300,376	1,236,268
Total Cost -- All sources of financing:	20,374,723	3,191,693	12,067,591	5,108,566	17,176,158
Total Cost -- Only MOH-financed:	16,189,346	3,191,693	10,798,619	2,188,513	12,987,131
Total Cost -- Only MOH-financed, additional direct outlays:	8,950,057	3,191,693	5,034,425	717,066	5,751,492
Revenues:	12,246,815	7,075,449			5,171,366

Administrative costs as a percent of the Regions' total IUFS revenues					
A. All Sources of Financing	166%	45%			332%
B. Only MOH-Financed	132%	45%			251%
B. Only MOH-Financed, Additional Direct Outlays*	73%	45%			111%
Net revenues of the Regions' institutional UFSs					
A. All Sources of Financing	(8,127,908)	3,883,756			(12,004,792)
B. Only MOH-Financed	(3,942,531)	3,883,756			(7,815,765)
B. Only MOH-Financed, Additional Direct Outlays*	3,296,758	3,883,756			(580,126)

Table 51
Administrative Costs of the Institutional User Fee System and Net Revenues Generated in National and Regional Hospitals in 1999
(In Lempiras)

Cost Element	Lempiras
Within Facility Labor Cost (regardless of source of financing)	1,940,985
Within Facility Labor Cost paid by the MOH	1,869,565
Central Government Cost	94,050
UPSs' Travel to Regional Office to Deposit Revenues	-
Regional Office Administration	-
Cost of Receipts	550,039
Total Cost -- All sources of financing:	2,569,871
Total Cost -- Only MOH-financed:	2,498,451
Revenues:	21,853,185

Administrative costs as a percent of the total IUFS revenues	
A. All Sources of Financing	12%
B. Only MOH Financed	11%

Net revenues of the institutional UFSs	
A. All Sources of Financing	19,283,314
B. Only MOH Financed	19,354,734

6. Community Participation

6.1 Introduction

There are four different mechanisms by which communities participate in the operations and governance of MOH facilities: community health boards, *patronato* health committees, municipal health committees and open town meetings (*cabildos abiertos*). Initially, this discussion will focus on the first three. For community health boards and municipal governments there were two sources of information; the facility questionnaire as well as two separate questionnaires that were developed for the health boards and the municipal governments. The information provided by the facilities was highly congruent with that provided by the respondents to the health board and municipal governments. Only when the responses in these separate questionnaires add insight will they be discussed here.

Table 52 shows the prevalence of each of the three types of committees by type of user fee system, facility and region. Community health boards are by far the most common form of community participation. Sixty percent of the surveyed facilities have a board, whereas only about a quarter had either a patronato or municipal health committee. There are more community health boards than there are municipal and patronato health committees combined. The righthand column of the Table shows the proportion of facilities that reported they had at least one of these three forms of community participation. Nearly four of every five facilities surveyed had at least one form of community participation. Only one of the 28 hospitals did not have some form of community participation. There is community participation in seventy percent of CESARs, and 50 percent of CESAMOs.

6.2 Community Health Boards

Sixty-two percent of the surveyed facilities report that there is a health board in their community. CESARs were much more likely to have a health board than were CESAMOs, and the average amount of time that they had a board was significantly longer (calculated t statistic=2.62). While the average health board was started 5.5 years ago, as may be seen in Table 53, this average is distorted by some relatively very old boards that have existed for more than 30 years.

Health boards are becoming more common. More than half (55 percent) have been established in the last three years. Eighty-six percent of the health boards' members were elected to the board. In almost all instances, the election was a one-time event. It was held when the board was first established, and there have not since been new elections.

The typical health board has seven or eight members. In only a little more than half of the boards (55 percent) the facility is entitled to have a representative. The frequency of this right to representation varies by type of facility. Hospitals are more likely to be represented than a CESAMO, and a CESAMO is more likely to be represented than a CESAR (77, 69 and 41 percent, respectively). This probably reflects the greater prestige and political power of the higher-level facilities. In 58 percent of the communities where the UPS has a representative (which is just less than one-quarter, 23 percent, of all surveyed committees), this representative has the right to vote.

Table 52
Prevalence of Three Modes of Local Community Participation in Health: Community Health Boards, Patronato Health Committees and Municipal Health Committees

Characteristic	No. of Respon-dents*	*Community Has a Health Board*		*Patronato Has a Health Committee*		*Municipality Has a Health Committee*		*At Least One Type of Community Participation*	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Type of User Fee System									
Institutional	104	44	42%	30	29%	35	34%	76	73%
Community	66	57	86%	13	20%	11	17%	59	89%
Mixed	15	10	67%	3	20%	2	13%	11	73%
Type of Facility									
National Hospital	6	0	0%	5	83%	1	17%	6	100%
Regional Hospital	6	4	67%	4	67%	3	50%	6	100%
Area Hospital	16	9	56%	5	31%	8	50%	15	94%
All Hospitals	28	13	46%	12	43%	12	43%	27	96%
CESAMOs	72	36	50%	15	21%	26	36%	50	69%
CESARs	86	63	73%	19	22%	10	12%	70	81%
All Facilities	**186**	**112**	**60%**	**46**	**25%**	**48**	**26%**	**147**	**79%**
Region*									
Metropolitana	5	1	20%	2	40%	0	0%	3	60%
San Felipe	25	23	92%	8	32%	9	36%	24	96%
Comayagua	25	20	80%	1	4%	5	20%	20	78%
San Pedro Sula	26	8	31%	5	19%	6	23%	14	54%
Choluteca	30	15	50%	11	37%	7	23%	23	77%
Copan	17	8	47%	5	29%	9	53%	13	76%
La Ceiba	26	19	73%	6	23%	7	27%	21	81%
Juticalpa	19	15	79%	1	5%	0	0%	14	74%
Puerto Lempira	1	0	0%	0	0%	1	100%	1	100%
Regions' Totals	**174**	**109**	**63%**	**39**	**22%**	**44**	**25%**	**133**	**78%**

Table 53
When the Health Board was Formed

Year	Number	Percent	Cumulative Percent
Don't know	5	5%	
Before 1980	4	4%	4%
1980-1985	7	7%	10%
1986-1989	4	4%	14%
1990-1995	28	26%	40%
1996	5	5%	45%
1997	19	18%	63%
1998	24	22%	85%
1999	14	13%	98%
2000	2	2%	100%
Total	107	100%	

In response to an open-ended question, seventy-one percent of respondents indicated that their health board was founded "to support the facility," and another 6 percent said it was to help or to obtain the help of the community. (See Table 54.) These responses reflect a general interest in promoting community participation in the area of health. There were only two more specific reasons as to what prompted the establishment of the health board. They were to (1) manage or to collect user fees (11 percent) and (2) to more effectively petition for the refurbishing of an existing facility or for the construction of a new facility (6 percent).

Table 54
Why the Health Board was Formed

Motivation	Number	Percent
To support the UPS	79	71%
To manage/collect the user fees	12	11%
To help or obtain the help of the community	7	6%
To push for the refurbishing of a facility or the construction of a new facility	7	6%
Don't know	4	4%
Other	3	3%
Total	112	100%

The number of health committee meetings held in 1999 reported in the survey is shown in section A of Table 55. Ninety-five percent of the respondents reported that their committee had met during 1999. Two of the committees that had not met in 1999 had already met in year 2000 prior to their interview. Thus 99 percent of the health committees had a meeting within the 15 months prior to being interviewed.

Thirty percent of the committees reported having had a meeting one month ago or less, 62 percent two months ago or less and 86 percent within the last quarter. (See Section B of Table 55.) The most common (modal) pattern, which characterized 40 percent of the health committees, is to have monthly meetings. The mean number of health committee meetings in 1999 was 9.3. These survey data are very similar to the number of health committee meetings reported to the MOH Statistics Unit on form AT2 in 1999. An analysis of the AT2 for 1999 found that the mean number per facility was 9.0 and the median was 8. According to the AT2 database, in 1999 the 1,121 MOH facilities had a total of 10,108 health committee meetings.

In sum, in the communities where they exist, health committees appear to be active, with regularly scheduled meetings. They act both to shape the health agenda and to augment the resources of, and, more generally, support the activities of their local health care systems.

Table 56 shows the board's current activities. Discussing health problems and the activities of the health facility were the most common activities of the boards, both reported by about 90 percent of the facilities with boards. The maintenance of the health facility building, purchasing supplies and the supervision of user fees are the other primary activities, each cited by roughly half or more of the respondents. In general, the level of the facility is inversely related to its health board's level of activity. The lowest level facilities', the CESARs', health boards are more likely to engaged in more different types of activities, are more likely to undertake each of the four principal types of health board activity and in 1999 met on average (median) 12 times, i.e., monthly. In the highest level facilities, the hospitals, health boards are least likely to undertake any given activity and they convened only about once every two months. The activity level of the CESAMOs' health boards is intermediate that of the hospitals and the CESARs.

About half of the health boards are involved in managing user fee revenues. The vast majority of these (83 percent) work with CESARs and 82 percent of them are community systems, with another 9 percent consisting of mixed systems. Of the 61 CESARs with community systems, 43 (70 percent) have a health board supervising their user fee revenues. In 70 percent of all community systems there is a health board that supervises user fee monies. The reader will recall that the RMRF stipulates that a community user fee system must be managed by a community health board. Thirty percent of the surveyed facilities with CSs are not in compliance with this requirement of the Regulation. Presumably the community component of the mixed systems is also required to adhere to this requirement. Here compliance is even lower: only 27 percent of mixed UFSs have a health committee that manages the system. (See Graph 41.)

Community systems are more likely than mixed systems and mixed systems are more likely than institutional systems to have a health board (86 versus 67 versus 30 percent, respectively). Of those systems with a health board, community systems are more likely than mixed systems and mixed systems are more likely than institutional systems to have a board that supervises its user fees (70 versus 27 versus 5 percent, respectively).

CESARs are more likely to have a health board than any other type of facility, and they are more likely to have a board that supervises user fees. As Graph 42 shows, 73 percent of CESARs have a health board compared to 54 percent of CESAMOs. Of health centers with a health board, CESARs

Table 55
Community Health Board Meetings
(60 Percent of Facilities, n=112, have a Health Board)

A. Number of Meetings in 1999

Number of Months	Number of Respondents	Percent of Respondents	Cumulative Percent
Don't Know	4	4%	
0	3	3%	3%
1	1	1%	4%
2	5	5%	8%
3	5	5%	13%
4	8	7%	20%
5	5	5%	25%
6	10	9%	34%
7	1	1%	35%
8	4	4%	39%
9	2	2%	41%
10	8	7%	48%
11	7	6%	55%
12	42	39%	94%
13-24	6	6%	99%
>24	1	1%	100%
Total:	**108**	**100%**	

Mean: 9.6
Median: 11.0

B. Number of Months Since the Last Meeting

Number of Months	Number of Respondents	Percent of Respondents	Cumulative Percent
Don't Know	5	4%	
<1 month	4	57%	57%
1	10	143%	200%
2	56	800%	1000%
3	14	200%	1200%
4	8	114%	1314%
5	1	14%	1329%
6	1	14%	1343%
7-12	10	143%	1486%
13-18	1	14%	1500%
>18	2	29%	1529%
Total:	**107**	**1529%**	

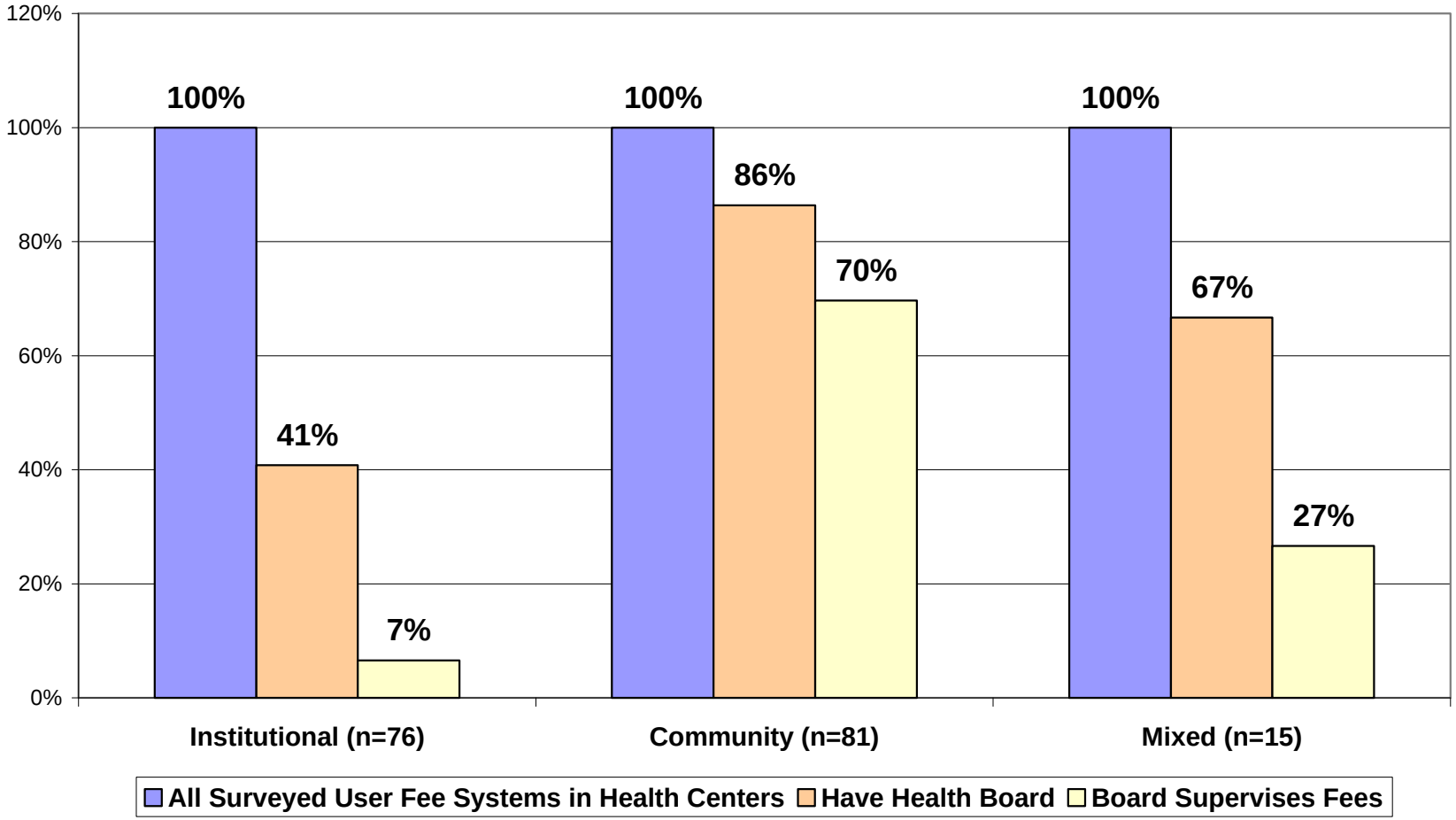
Mean Elapsed Time: 3.6 months
Median Elapsed Time: 2.0 months

Table 56
The Community Health Boards' Principal Activities, As Reported by Facility Interviewees

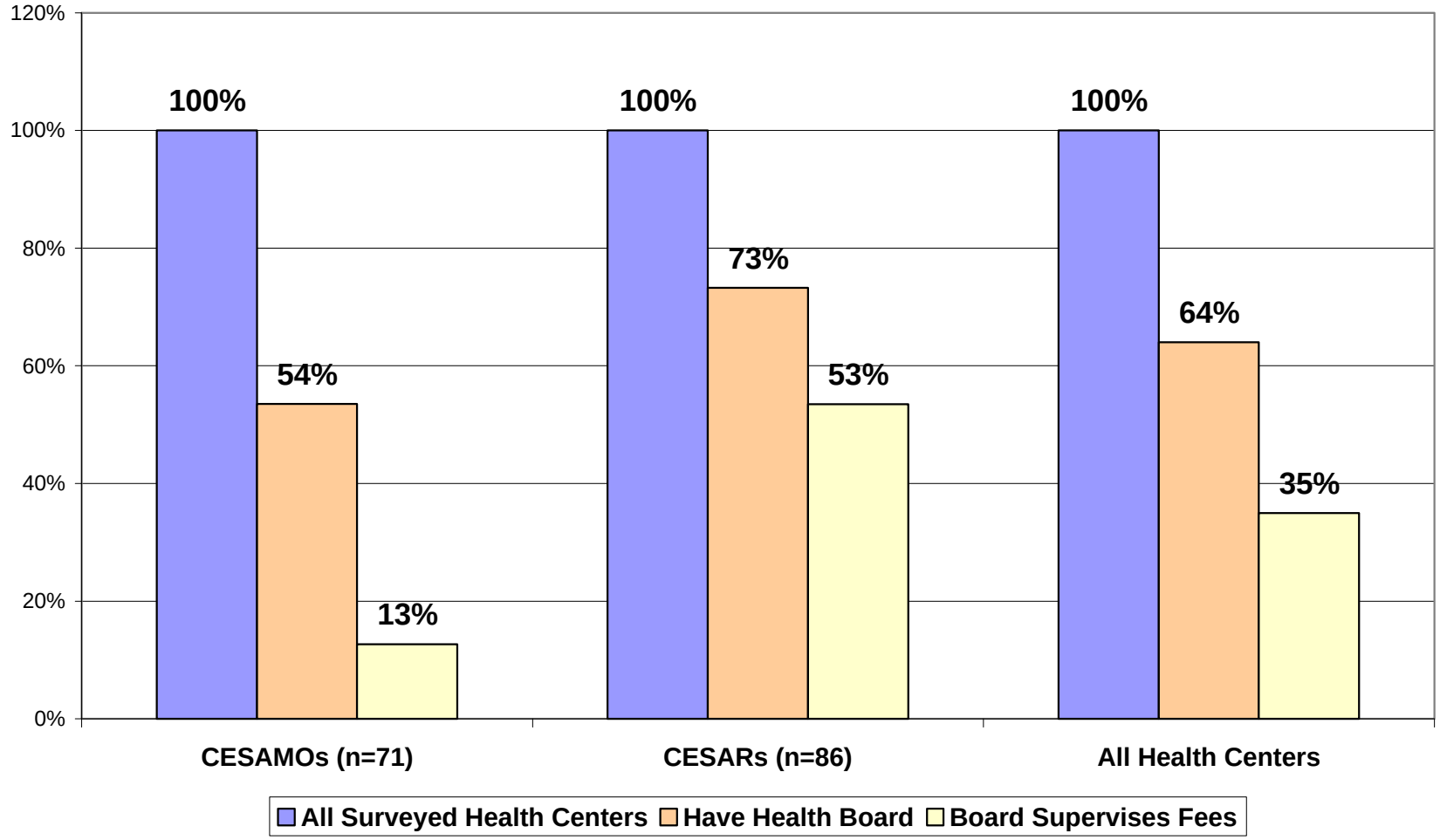
Activity	Regional Hospitals	Area Hospitals	CESAMOs	CESARs	All 4 Facility Types
Meetings to Discuss Health Problems	1	5	34	61	101
Percent of Each Facility Type	25%	56%	94%	97%	90%
Meetings to Discuss Activities of the Health Facility	2	5	31	61	99
Percent of Each Facility Type	50%	56%	86%	97%	88%
Maintenance of the Health Facility's Physical Infrastructure	1	2	25	53	81
Percent of Each Facility Type	25%	22%	69%	84%	72%
The Purchase of Supplies for the Health Facility		5	15	45	65
Percent of Each Facility Type		56%	42%	71%	58%
Supervision of the Health Facility's User Fees			9	46	55
Percent of Each Facility Type			25%	73%	49%
Physical Rehabilitation or Remodeling of Facility	1	2			3
Percent of Each Facility Type	25%	22%			3%
Number of Facilities with Health Boards Responding	4	9	36	63	112

Graph 41: Proportion of Surveyed User Fee Systems with Health Boards and Boards that Supervise User Fee Revenues

(includes only CESAMOS and CESARs)



Graph 42: Proportion of Surveyed User Fee Systems with Health Boards and Boards that Supervise User Fee Revenues



are more likely than CESAMOs to have a board that supervises its user fees (73 percent versus 24 percent, respectively). Fifty-three percent of the surveyed CESARs and 13 percent of the CESAMOs have health boards that supervise their user fees.

6.2.1 The Need for Health Facility Representation on Community Health Boards

The most common activities of the health boards involve public discourse about health problems and about the operations of the local health facility. It makes sense, therefore, to have a representative of the facility on the board. Where this is the case, it likely enhances the health worker's stature in the community and probably gives them a greater sense of professionalism and responsibility, and they are more apt to take greater pride in their work. This is especially likely to be the case with CESAR personnel, and, recall, it is CESARs that are most likely to have a health board, but are the least likely to be represented on the board. Furthermore, it is the CESARs that are most likely to have a community user fee system, most of which have boards that supervise and/or manage their user fee systems.

Clearly, it would be advisable to, at minimum, encourage local authorities to enable the participation of the health facility's personnel in the decisions as to how user fees should be managed and spent, and all of the other decisions dealing with health and the health facility. Consideration should be given to making it a requirement of the health boards if they are to continue to be delegated the authority for managing community user fee system revenues.[18] Given the renewed emphasis on community participation and decentralization in Honduras, and specifically in the MOH, a strong case can be made for periodically holding health board elections, rather than simply allowing those that have been formed—however, long ago—to perpetuate, *ad infinitum*. **It is recommended that the MOH develop guidelines or regulations governing the formation and composition of health boards, as well as suggestive operating procedures and protocols. Due consideration should be given to ensuring that a representative of the local health facility is guaranteed a position on the board.**

6.2.2 Are the Numerous Newer Health Boards Different?

An analysis investigating systematic differences by the longevity of health boards, revealed only minor differences. The newer boards (those started in the last 3 years) are more likely to be smaller (averaging 7 persons, the older ones 10 persons), they are more likely to meet once every three or four months, the older ones meet monthly, and, while the vast majority of their members are elected, their members are twice as likely to have been appointed rather than elected. The reason health boards have been established has not changed over time, and the types of activities younger and older boards are involved does not vary. Restricting the analysis to just community or mixed systems, the facilities with younger health committees have significantly higher prices (mean=3.44 vs 2.76; calculated t statistic=2.03) and are more likely to charge for some service the MOH mandates should be free-of-charge (mean=0.84 vs 1.00; calculated t statistic=2.61). When just the CESARs are

[18] It may be that the non-representation of the health facility on the board, at least in some instances, is an artifact of the way in which the health boards have been established or historically developed. In many facilities it is likely that the MOH personnel at a facility have changed (due to transfers, rotation or attrition) since the health board was first formed, and consequently, those facilities that once had a representative on the board may have lost that position.

analyzed, the facilities with younger health committees are also found to have higher prices (mean=3.47 vs 2.55; calculated t statistic=2.60).

6.2.3 Regional Variations in the Prevalence of Health Boards

There are four regions that have substantially higher proportions of facilities with health boards: San Felipe, Comayagua, Juticalpa and La Ceiba. These same four regions also have significantly higher proportions of facilities with at least one type of community participation. There are some indications that these regions are characterized by a higher-level of organization. For instance, the price of a general consultation in the facilities of these regions is generally higher and more uniform. For instance, in Comayagua 92 percent of facilities charge 2 lempiras, and in Juticalpa nearly two-thirds of the facilities charge 5 lempiras. The more urbanized regions of Metropolitana and San Pedro Sula have the least community participation through health boards, which may reflect, at least in part, their more urban character.

In four regions—Metropolitana, San Pedro Sula, Choluteca and Copán—it appears that patronato and municipal health committees are more likely to be substitutes rather than complements to the health boards. That is, if a facility in these regions has a health board, it is more likely not to have either of these two forms of community participation, and vice versa. Facilities in these regions are far less likely to have both. Thus, the difference in these regions between the number of facilities with at least one type of community participation and those with a health board is substantially greater than it is in other regions.

6.3 Patronato Health Committees

Twenty-two percent of the 186 respondents reported either that they did not have or did not know if there were any patronatos or support committees in their community. The remaining 78 percent, reported that there was a median of one and a mean of 2.9 such committees. Thirty-two percent of the communities that have one or more patronatos, have a patronato health committee. Thus, 25 percent of all of the surveyed facilities have a patronato health committee. Local facility representation on patronato health committees is greater than it is on health boards. A representative of the local health facility is reported to participate on three-quarters of the patronato health committees, compared to 55 percent of health boards. Like health boards, patronato health committees are routinely quite active, meeting on average once every three or four months. This is only half as often as the typical health board.

Whereas community systems were more than twice as likely as institutional systems to have a health board, the institutional systems were nearly 50 percent more likely to have a patronato health committee and twice as likely to have a municipal health committee. There are discernable patterns of facility types and forms of community participation, too. None of the national hospitals has a community health board, though 83 percent of them have a patronato and all of them have at least one form of community participation. The CESARs have the highest level of health board participation, but the lowest via municipal health committees. CESAMOs, on the other hand have three times the CESARs' participation rates for municipal health committees, 12 and 36 percent respectively, but have health board participation rates that are only two-thirds those of the CESARs'.

Table 57 shows the principal activities of the patronato health committees. The rank ordering of the responses was identical to that of the community health boards, although the proportion of facilities reporting they participated in any particular activity was substantially less. Whereas 88

Table 57
The Patronato Health Committee's Principal Activities, As Reported by Facility Interviewees

Activity	National Hospitals	Regional Hospitals	Area Hospitals	CESAMOs	CESARs	All 5 Facility Types
Meetings to Discuss Health Problems	1	2	3	15	17	38
Percent of Each Facility Type	20%	50%	60%	100%	89%	79%
Meetings to Discuss Activities of the Health Facility	3		3	13	18	37
Percent of Each Facility Type	60%		60%	87%	95%	77%
Maintenance of the Health Facility's Physical Infrastructure	3		1	10	9	23
Percent of Each Facility Type	60%		20%	67%	47%	48%
The Purchase of Supplies for the Health Facility	3		2	4	6	15
Percent of Each Facility Type	60%		40%	27%	32%	31%
Supervision of the Health Facility's User Fees				2	3	5
Percent of Each Facility Type				13%	16%	10%
Physical Rehabilitation or Remodeling of Facility		1	2			3
Percent of Each Facility Type		25%	40%			6%
Other	2			3		5
Percent of Each Facility Type	40%			20%		10%
Number of Facilities with Patronato Health Committees Responding	5	4	5	15	19	48

percent of health boards are associated with CESARs and CESAMOs, this share falls to 69 percent for patronato health committees. Patronato health committees, are much more the creatures of hospitals, and to a lesser extent CESAMOs. They are also less likely to get undertake the types of activities which are more likely to entail being involved in more detailed day-to-day operations of the facilities. The proportions of patronato health committees that participate in the maintenance of the health facility's infrastructure, that purchase supplies for the facility and especially that supervising user fees, are all substantially less than is the case with the community health boards.

6.4 Municipal Health Committees

It is interesting to note that one-third of the respondents said they did not know if there was a municipal health committee. This high level of ignorance about the health activities of the municipality must be construed as reflecting a commonly wide gulf between the activities and operations of the health facility and those of the municipal government in many municipalities. Twenty-six percent of the surveyed facilities (including those that did not know), reported that the municipality had a health committee.

Table 58 shows the municipal health committees's activities. The rank ordering of the five principal activities of the municipalities' health committees is identical to that of both the patronato health committees and the community health boards. In comparison to the other forms of community participation, the municipal health committees are more likely to be working with CESAMOs, and, in both the CESAMOs and CESARs with which they work, they universally engage in discussions about the health problems of the municipality.

6.5 Multiple Forms of Participation in the Same Community

Table 59 shows the number and percent of each form of community participation engaging in each of the five major types of activities reported. The right-hand column shows the number and proportion of facilities in which there is community participation in each of the activities. Graph 43 shows the overall level of community participation in the 186 surveyed facilities by type of activity, regardless of which of the three organizational forms is involved. The most common type of community participation involves meetings to discuss health problems, which occurs in 72 percent of the sample. More than two-thirds of the sample reported that there are meetings to discuss the local health facility's activities and operations. The three remaining activities are more specific and may be more directly involved in the operations of the health facilities. Communities provide support in facility maintenance in more than half of the facilities. The purchasing of supplies is the most common type of activity that necessarily involves the direct outlay of monies, although that may also be an outcome of the discussion meetings and maintenance efforts as well. Forty-four percent of the facilities reported their communities' aid them by purchasing supplies. One-third of the sample said the community supervises their user fee system. Whereas 59 percent of the health boards indicated that they supervised user fees, only 14 percent of the mayors' offices said they did so. Generally municipal governments are less active and less involved in as many different types of activities as are the community health boards.

Graph 44 shows the breakdown of community participation activities by type of user fee system. For each of the five identified activities, the facilities with a community user fee system have the highest community participation rates, and those with institutional user fee systems have the lowest rates. The facilities with mixed systems have intermediate levels of community participation. The more specific the activity and the more it involves working directly with the facility on things

Table 58
The Municipal Health Committee's Principal Activities, As Reported by Facility Interviewees

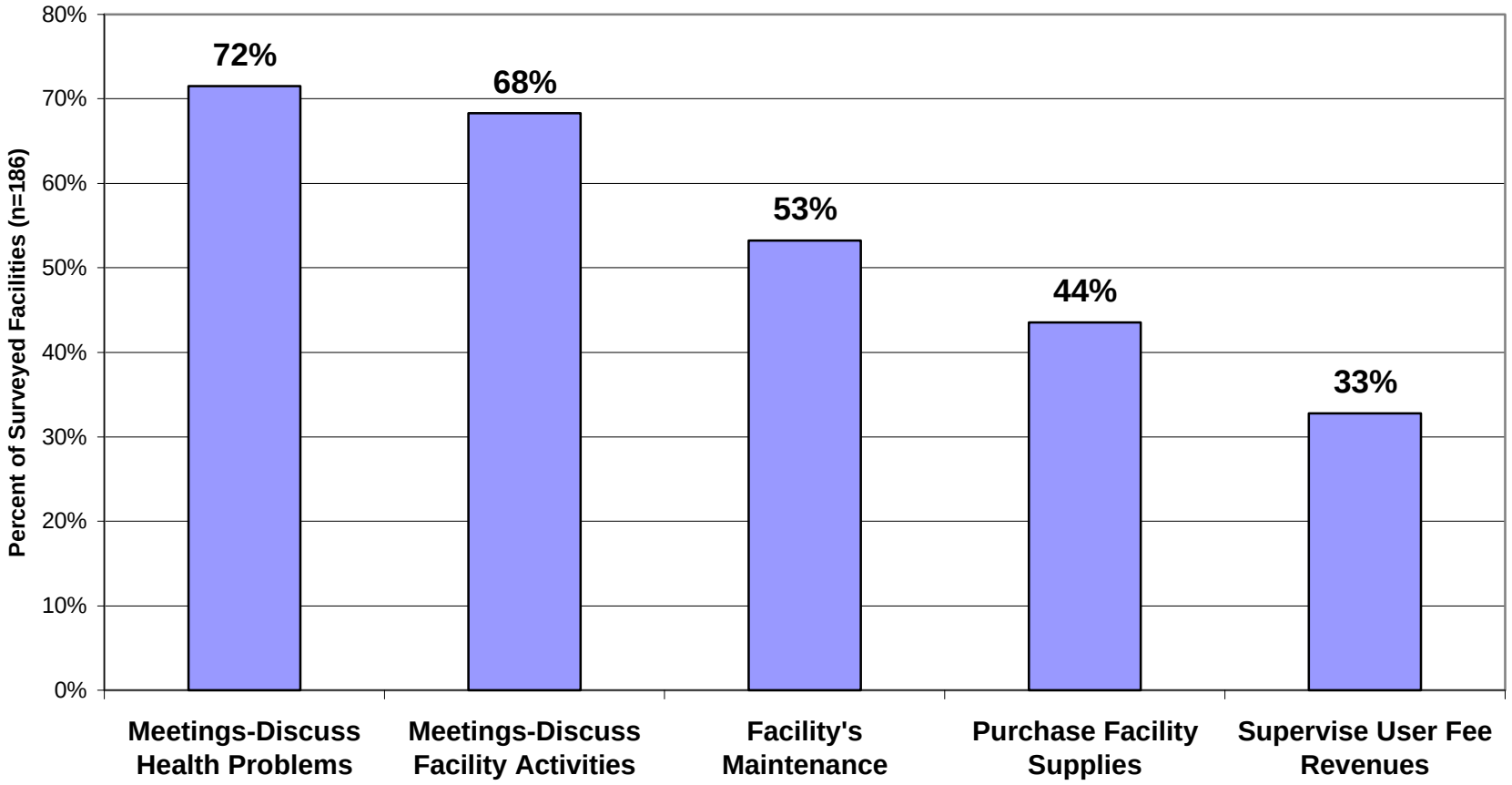
Activity	National Hospitals	Regional Hospitals	Area Hospitals	CESAMOs	CESARs	All 5 Facility Types
Meetings to Discuss Health Problems	1	2	7	26	10	45
Percent of Each Facility Type	100%	67%	88%	100%	100%	94%
Meetings to Discuss Activities of the Health Facility		1	2	18	6	27
Percent of Each Facility Type		33%	25%	69%	60%	56%
Maintenance of the Health Facility's Physical Infrastructure			2	14	3	19
Percent of Each Facility Type			25%	54%	30%	40%
The Purchase of Supplies for the Health Facility			2	9	3	14
Percent of Each Facility Type			25%	35%	30%	29%
Supervision of the Health Facility's User Fees				4	3	7
Percent of Each Facility Type				15%	30%	15%
Number of Facilities with Municipal Health Committees, Responding	1	3	8	26	10	48

Table 59
Community Participation by Type of Activity and Type of Participation Vehicle

Activity	Community Health Boards		Patronato Health Committees		Municipal Health Committees		At Least One Type of Community Participation	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Meetings to Discuss Health Problems	101	90%	38	79%	45	94%	133	72%
Meetings to Discuss Activities of the Center	99	88%	37	77%	27	56%	127	68%
Maintenance of the Center's Physical Infrastructure	81	72%	23	48%	19	40%	99	53%
The Purchase of Supplies for the Center	65	58%	15	31%	14	29%	81	44%
Supervision of the Center's User Fees	55	49%	5	10%	7	15%	61	33%
Number of Facilities Responding	**112**	**100%**	**46**	**100%**	**48**	**100%**	**186**	**100%**

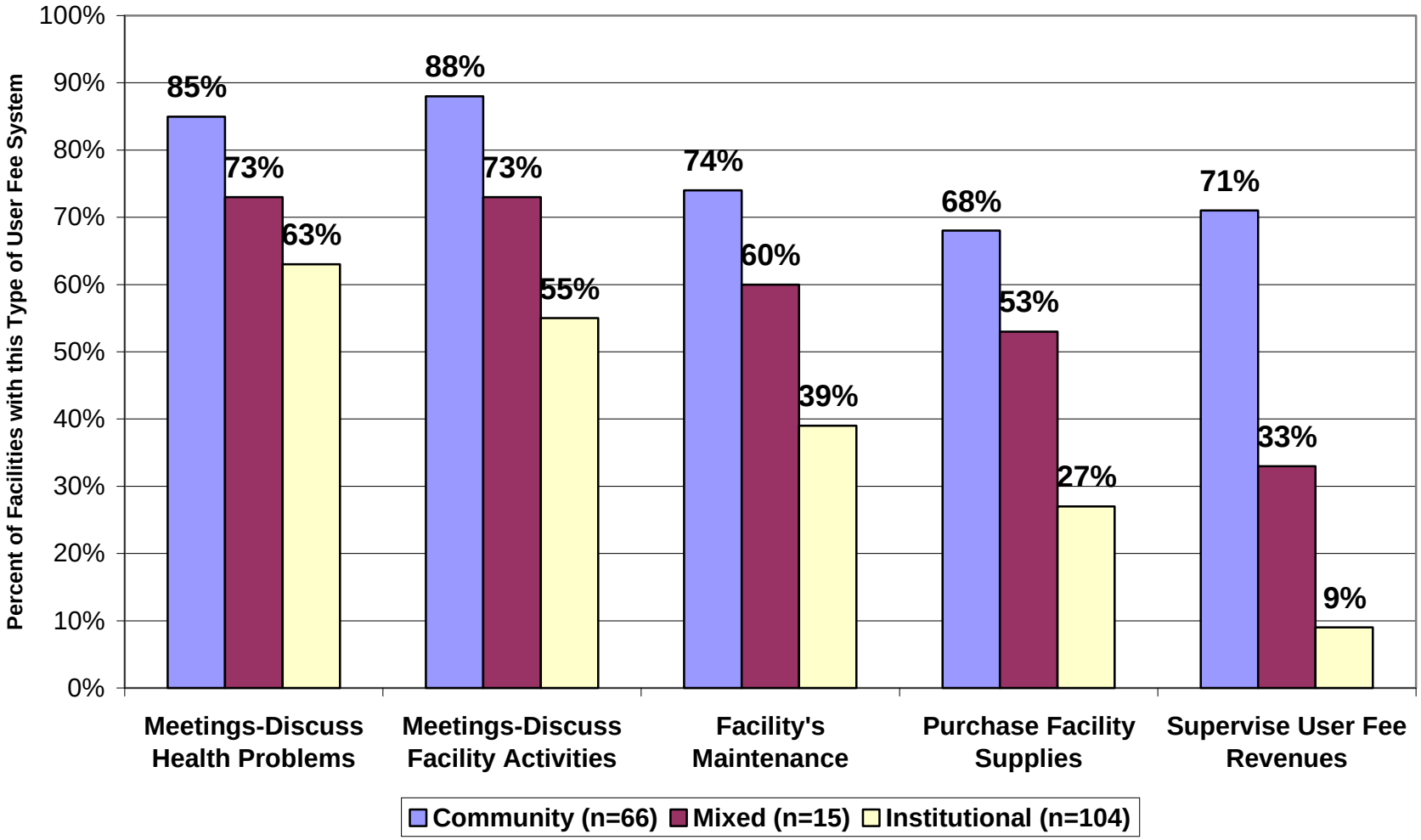
Graph 43: Proportion of Facilities with Community Participation by Type of Activity

(Possible Forms: Community Health Board, Patronato or Municipal Health Committee)



Graph 44: Community Participation by Activity and Type of User Fee System

(Includes All Three Types of Community Participation Mechanism)



involving its day-to-day operations, the greater are the differences in the rates of the three types of systems. The two activities in which the differences are most mark are purchasing supplies and, especially, supervising user fee systems.

In more than 80 percent of the facilities in which the community supervises user fees the community also buys supplies for the facility. The converse, however, is less common; only 57 percent of the facilities in which the community purchases supplies does it also supervise user fees. Where communities participate through a health board these two activities are both more prevalent and more likely to go hand-in-hand, suggesting that there is a more intimate relationship between the community and the facility. Among the facilities with health boards, 80 percent that supervise user fees also purchase supplies and nearly 70 percent of the facilities that purchase supplies also supervise user fees. In contrast, patronato health committees are just as likely to buy supplies if they supervise the user fee system, but only a quarter of those that buy supplies also are involved in the supervision of user fee monies. This suggests that the typical patronato health committee's mode of participation is more distant and more directing, and less involved in the day-to-day operations and management of the facility. The municipal health committees follow a pattern that is intermediate these two modes.

Graph 45 shows the degree of overlap between the three organization vehicles of community participation; i.e., the extent to which there are multiple forms of participation in any one of the surveyed health facilities. Twenty-seven percent of all of the facilities surveyed, and 35 percent of those that have at least one formal mechanism of community participation, have more than one. This raises the issue as to whether there are conflicts between the organizations that are simultaneously participating. Table 60 shows the extent of multiple vehicles of community participation by type of activity. Here we see that there are a fair number of facilities in which different community organizations are participating in the same type of activity. For instance, in one-third of the surveyed facilities where the community gets involved in meetings to discuss health problems, there is more than one organizational vehicle holding these meetings. While this may not be problematic if the activity stays at the level of discussions, but if courses of action are identified and there is a need to use the facility's resources, it is possible that conflicts could arise. The potential for conflict is most obvious in the supervising of user fees. While only 8 percent of the facilities in which the community supervises the user fee system reported that there was more than one organization involved in the supervising, what happens if there are differences of opinion? How are they resolved? Does it end in a political battle in which the health facility is a pawn? Particularly in light of the fact that the health facility frequently does not even have representation on the organization, it is not clear that health facility is necessarily well served by these arrangements.

In light of the Government of Honduras' and the MOH's efforts to promote both community participation and decentralization, it is recommended that national authorities provide some guidance in terms of the types of structures, and operating procedures and domains for local entities interacting with entities of the MOH. The goal should be to promote community participation while obviating conflict and protecting the integrity and operations of the local health care facility.

6.6 Municipal Support of the Local Health Facility

6.6.1 Central Government Funding of the Municipalities

Over the past few years, Honduras has been developing a framework for, and has embarked on the process of decentralization. An important component of that effort has been the December 1999 modifications of the Law of Municipalities. Article 91 of the modifications establishes a new

Graph 45: Number of Community Participation Mechanisms in Each Surveyed Health Facility

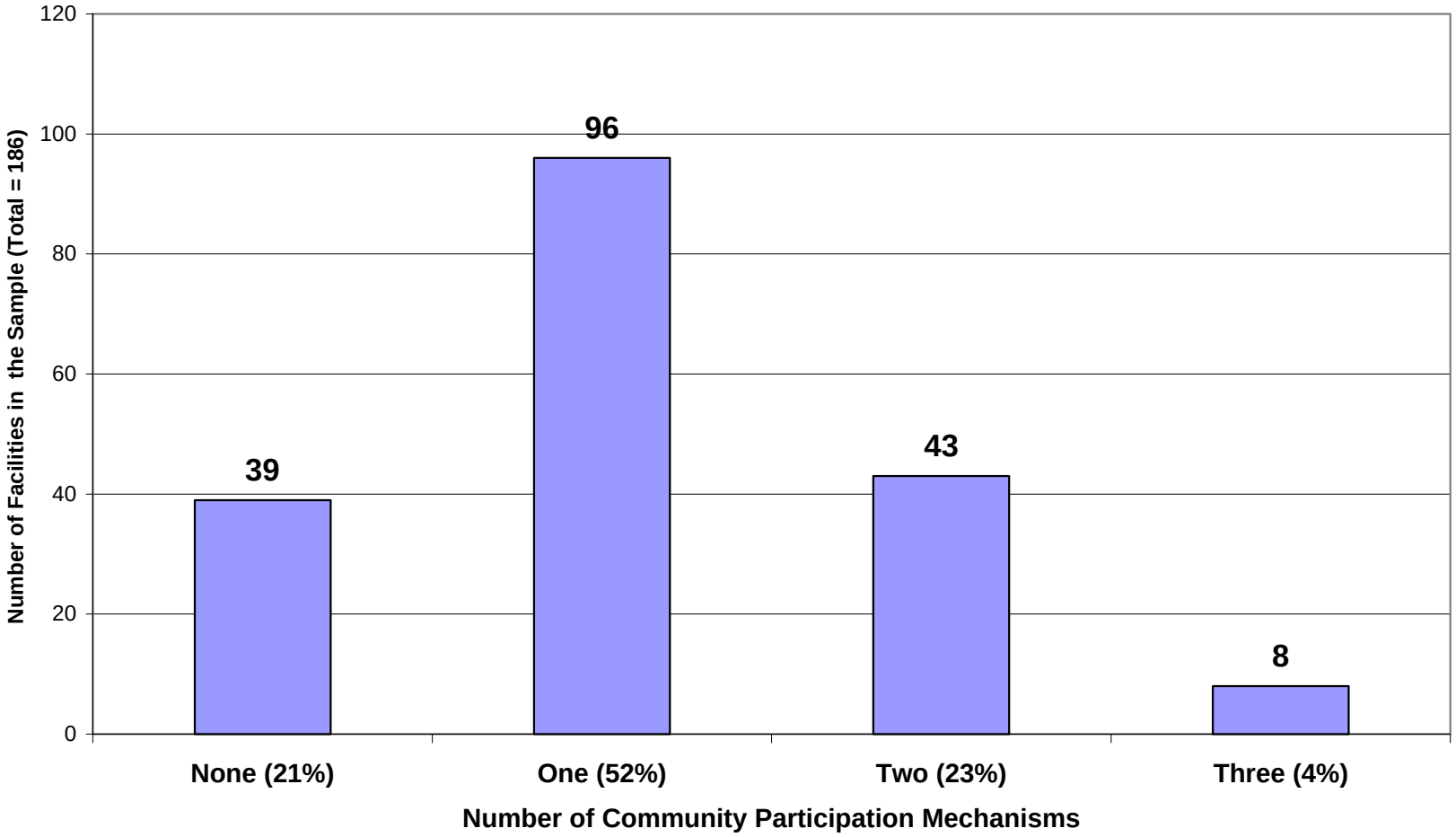


Table 60
Community Participation by Type of Activity and Number of Participation Vehicles

Potential Vehicles are Community Health Board, Patronato and Municipal Health Committees

Activity	At Least One	More than One Type of Participation		
		Number	% of At Least One	% of all Facilities
Meetings to Discuss Health Problems	133	44	33%	24%
Meetings to Discuss Activities of the Center	127	34	27%	18%
Maintenance of the Center's Physical Infrastructure	99	20	20%	11%
The Purchase of Supplies for the Center	81	11	14%	6%
Supervision of the Center's User Fees	61	5	8%	3%

mechanism for funding municipalities. Each year the municipalities are to receive five percent of the total tax income of the Central Government. Four of the five percent (80 percent of the total sum) is to be distributed equally among the municipalities, with the remainder allocated in proportion to population. The law contains various restrictions on the use of the monies, including allowing up to a maximum of five percent to be used for the operation and maintenance of the "social infrastructure." It provides some specific examples of what these expenditures may cover, including paying the salary of nurses.

In an interview with a high-ranking official of the Ministry of Finance (MOF) it was learned that the MOF currently transfers less than half of the five percent established by law. The official explained that they feel that there are municipalities that do not have adequate administrative capacity to appropriately manage these monies, and that it (MOF), therefore, had made a determination to withhold the monies from such municipalities. No information was obtained about the number of municipalities so regarded. In the estimation of the official interviewed, it will be several, perhaps many, years before it expects to be transferring the full five percent.

No information was obtained about the sources of financing of the municipal support that is discussed in this section. It is not known if the facilities in the municipalities surveyed were beneficiaries of expenditures of the five percent revenue sharing, or even if their municipality is receiving any of these revenue sharing monies. These information gaps are important in that they undermine our ability to gauge the significance of these expenditures by the municipalities. Still, at minimum, these expenditures reflect that municipalities value health and feel that their local facility needs financial assistance to be better able to provide a more acceptable level of care.

6.6.2 Types of Municipal Support to MOH Facilities

Fifty-eight percent of the surveyed facilities receive some type of assistance from their municipal government. Municipalities with a health committee were 54 percent more likely to provide assistance to their local health facility than were municipalities without a health committee.[19] Still, nearly half of the municipalities without a health committee provided some type of support to their local facility. Excluding one outlier, the mean level of support is nearly 15,000 lempiras annually. When averaged over only those facilities receiving at least one of the five potential types of municipal support, the average is more than 38,000 lempiras.

The 186 facilities received 5.5 million lempiras in municipal assistance. This is the equivalent of 24 percent of their total user fee revenues of 23 million lempiras. National hospitals, which alone accounted for 41 percent (9.4 million lempiras) of the user fee revenues of the sample, do not receive any municipal assistance. If we exclude them from the analysis we find the 5.5 million lempiras in municipal aid is the equivalent of 40 percent of the total user fee revenues of the remaining 180 facilities. While all but one of the sample facilities garners user fees, (as already noted) only 58 percent of them receive municipal government support. Restricting the analysis to the 94 facilities for which there are observations on each of the five types of municipal assistance and which have received some municipal aid, the value of municipal aid comes to 85 percent of the 1999 user fee revenues. **In other words, in the more than half of MOH facilities that receive support from their municipal government, the value of that support on average approaches the value of their user fee revenues.**

[19]The difference in these proportions is statistically significant at the 99 percent level. The calculated t statistic is 3.30.

The interviewees were asked about the types and values of support provided by the municipality. Table 61 presents these data. A few comments on the structure of the table are in order. First, the number of facilities that responded to whether or not support was received from the municipality was always greater than the number that could provide information on the value of that support. Thus the number of respondents to both of these questions is provided in the table, in the second and fourth columns from the left. Second, in calculating the average contributions, there was wide variation in the value of support provided, with a few facilities receiving very large contributions and the remainder much more modest amounts. This results in the means being skewed to the right, and prompted including the medians as an alternative measure of the "average." Finally, it is useful to have information about the average value of the contributions for all interviewed facilities, yet it is also insightful to be able to distinguish the level of aid provided by those that received some positive amount. Accordingly, averages are presented using both of these denominators.

As may be seen in the Table the most common form was for the municipality to provide logistic support. Thirty-one percent of all interviewees and 53 percent of the facilities receiving some type of assistance from their municipal government reported receiving logistical support valued. Averaged over the entire sample, the value of this assistance was 811 lempiras annually per facility, or 2,903 lempiras when averaged over only those receiving some logistic support. The mean and median values of the logistic support provided, and of each one of the other four different types of support, as well, vary dramatically.

The second most common type of support is for the municipality to pay the salary of health facility employees. Fifty-four facilities, 29 percent of the sample, reported receiving this type of support and together they received 4.8 million lempiras of aid. One facility, Regional Hospital Leonard Martínez, has 18 staff-persons that are paid for by the municipality at an annual cost of 3.14 million lempiras. This high level of assistance—accounting for 57 percent of the total municipal aid to the sample facilities—seriously distorts the mean contributions, and prompted recalculating several of the measures without this outlier. The mean number of persons paid by the municipality per facility was 1.8, and the median was one. The average monthly salaries of these persons, were also highly skewed; the mean was 17,425, while the median was 5,100 lempiras, reflecting the dfferent kinds of personnel hired—from night watchmen and cleaners to nurses and physicians.

Forty-one facilities (22 percent of the sample) receive support for purchasing goods or refurbishing the facility. Those that received some such aid received a mean of 11,523 lempiras and a median of 2,000. Total assistance of this type among the entire sample was just less than 400,000 lempiras in 1999.

Fourteen percent of the facilities in the sample (26) reported that their municipal government had purchased supplies for them during 1999. The mean value of supplies contributed was 8,206 lempiras, and the median was 2,250.

The final category of aid received by the sample facilities from their municipal government was financial assistance. Twenty-two (12 percent) of the sample was given financial assistance in cash from the municipality. The mean cash contribution was 6,502 lempiras, and the median was 2,400.

Graph 46 shows the value of the five categories of assistance. Paying for personnel is by far the most important source of assistance from municipal governments, accounting for at minimum two-thirds of the total. If the outlier facility is figured into the calculations, personnel comes to constitute 87 percent of the value of municipal assistance.

Table 61
Support Provided to the Local MOH Facility by the Municipal Government in 1999
As Identified by Health Facility Interviewees

Type of Support Provided	Number of Facilities Receiving	Percent of Interviewees	Number of Interviewees Providing Value Estimates	Average Value of the Contribution in Lempiras: Averaged Over All Interviewees Without User Missing Data (n=186 maximum) No.Interviewees	Mean	Median	Avg'd Over Only the Interviewees Providing Value Estimate of This Type of Contribution Mean	Median	Total Contribution Provided
Provided logistic support	57	31%	50	179	811	0	2,903	1,000	145,130
Pay the salary of UPS employees	54	29%	54	186	25,613	0	88,222	6,180	4,763,968
Exclusive of one outlier	53	28%	53	185	8,778	0	30,641	6,000	1,628,964
Paid for goods, refurbishing the UPS	41	22%	34	179	2,189	0	11,523	2,000	391,778
Purchased supplies for the UPS	26	14%	22	182	992	0	8,206	2,250	180,530
In-cash allocation	22	12%	20	184	707	0	6,502	2,400	130,046
Total Support Provided:	**108**	**58%**	**76**	**186**	**29,338**		**50,614**		**5,466,322**
Including only facilities for which there is non-missing data on all 5 types of support	**172**			**172**	**29,540**	**225**	**54,053**	**3,850**	**5,080,952**
As above, exclusive of one outlier	**171**			**171**	**11,350**	**200**	**20,870**	**3,700**	**1,940,948**

As may be seen in Graph 47, after national hospitals (none of which receive any assistance), CESARs are the least likely and CESAMOs the most likely type of facility to receive municipal support. Forty-nine percent of the CESARs in the sample received aid, compared to 74 percent of CESAMOs.[20]

Community systems are significantly less likely than either institutional or mixed user fee systems to receive municipal assistance and they receive less municipal aid.[21] Although 35 percent of the surveyed facilities have community user fee systems and 45 percent of them receive municipal assistance, they receive only 103,310 lempiras, or seven percent of the total value of that assistance (two percent if the outlier is included in the calculations). Facilities with community user fee system receive a mean of 1,639 and a median of zero lempiras of municipal aid, compared to institutional systems' mean of 48,306 and median of 370, and mixed systems' 28,355 and 9,100 lempiras.

6.7 Open Town Hall Meetings

Seventy-six (41 percent) of the interviewees reported that there were open town hall meetings where the activities of the local health facility are discussed. (Twenty percent reported they did not know if there were such meetings.) On average, the last such meeting was reported to have been held four months ago. Ninety-two percent of the last meetings had been held within the past year. In other words, within the past year, 38 percent of the surveyed facilities' communities had a town hall meeting where the activities of the local health facility had been discussed. This is evidence of the high level of community participation that characterizes the public health sector of Honduras.

The topics of discussion at the last town meeting are presented in Table 62. Specific types of health problems dominated the discussions, but health care financing issues and the need to enlarge or otherwise remodel the health center building were also common topics. The specific issue of increasing user fees was identified twice.

Interviewees were also asked if there had ever been discussions about user fees in open town hall meetings. Sixteen respondents (nine percent of the entire sample and 18 percent of the facilities with open town hall meetings) reported that there have been. On average the last time user fees were discussed at a town meeting was four or five months ago. By far the most common theme of these meetings (69 percent) was the level of user fees. In one instance there was discussion of the need to lower the fee level of a particular service. In the other 10 meetings the need to raise fee levels was the topic of discussion.

6.8 Conclusion

There exists a substantial amount, and a variety of forms of, community participation in the health sector of Honduras. There are clear patterns of participation discernable. Within CESARs it is usually the community health board that is most active, whereas in CESAMOs it is more common for municipal health committees and patronatos to be involved. The bulk of the support provided by

[20] The difference is statistically significant at the 99 percent confidence level. The calculated t statistic is 3.25.
[21] The calculated t statistics are 2.07 and 2.19, respectively, (both significant at the 95 percent confidence level) for the community-institutional systems and 3.85 and 2.71 for the community-mixed system comparisons (both significant at the 99 percent confidence level).

Graph 47: Proportion of the Surveyed Facilities Receiving Municipal Government Support

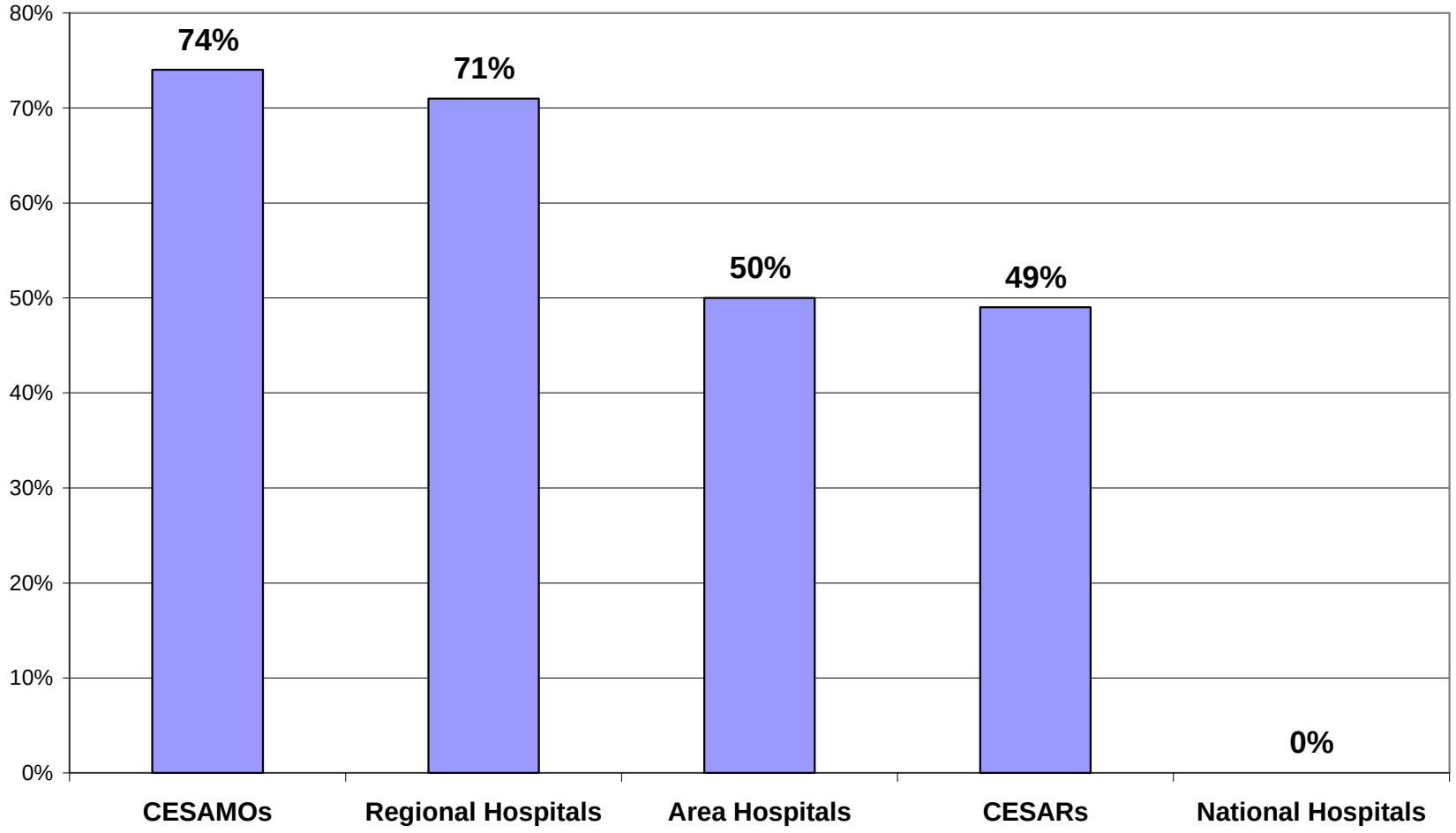


Table 62
Health Topics Discussed at the Last Open Town Hall Meeting

Topics	Number	Percent
Health Care Financing	**14**	**20%**
Financing water and sanitation projects	7	10%
Increasing user fee levels	2	3%
Hiring and paying personnel for the center	5	7%
Physical Infrastructure	**12**	**17%**
Enlarging the health center	5	7%
Constructing a health center and letrines	5	7%
Improving the health center	2	3%
Coordination/Overall Management	**22**	**31%**
Identifying the major health problems	8	11%
Coordinating the Vaccination Campaign	5	7%
Reporting activities of the health center	2	3%
Organizing emergency shelter	1	1%
Forming a health board	2	3%
Establishing the community's health priorities	2	3%
Reporting on all health programs	2	3%
Specific Types of Health Problems	**23**	**32%**
Environmental health and sanitation	13	18%
Contamination of water sources	2	3%
Malaria, dengue and measles	4	6%
Malnutrition	1	1%
Alcoholism	1	1%
Maternal mortality	1	1%
Need for an ambulance	1	1%
TOTAL	**71**	**100%**

the community to the health facility comes from patronatos and municipal governments (with or without municipal health committees), and the beneficiaries are generally the CESAMOs. CESARs are much more likely to be dependent for supplementary support on their user fee systems.

There is a clear trend of growing community participation, particularly in the form of community health boards. At least in part, this recent upsurge has been encouraged by the Central Government's recent revision of the Law of Municipalities, which was enacted to promote decentralization. By mandating that five percent of the Central Government's total revenues be transferred directly to municipalities, Hondurans have been given more impetus to participate in their communities' governance. Moreover, the Law of Municipalities further mandates that open town hall meetings be held regularly, where concerns about health and health care are a common topic of discourse. In sum, decentralization is already occurring in the health sector and it is becoming increasingly common. Municipal governments are interested in, and directly supporting, nearly 60 percent of the facilities surveyed. This is the future direction of the country and provides an important contextual consideration that must be taken into account in deciding how to modify the UFSs of the MOH.

7. Interviewees' Views of UFS Problems, Possible Solutions and A Proposal for an Alternative Institutional Structure

7.1 Introduction

The MOH facility interviewees were asked two sets of questions about what they regarded as the key problems of the user fee systems. One set of questions had a screen question that asked if the RMRF rules and regulations should be modified or reformed. Those who responded affirmatively were then asked questions about 10 specific RMRF regulations and whether they created problems for operating UFSs. An eleventh question was open-ended, asking if there were any other UFS problems that were RMRF-related. Respondents who identified more than one RMRF problem were asked to prioritize the problems as top priority or secondary priority. The second set of questions consisted of an open-ended question about what they thought were the most critical problems of their UFS. A follow-up question asked what could be done to resolve the identified problem(s).

Finally, interviewees were asked their opinion about a specific alternative to the current institutional UFS structure: What do you think about the possibility of supplanting the regional office as the supervisor of ISs with the Municipal Government.

7.2 UFS Problems due to RFRM Regulations: Responses to an Open-Ended Question

All (100 percent) of the interviewees of institutional systems said the RFRM needed to be changed. The rank-ordered responses to the questions are presented in Table 63. The most common responses, each cited by more than 60 percent of the respondents, were restrictions that established specific lempira-defined ceilings (before obtaining price quotes is required, for rotating funds and for medicine purchases) reflecting the impact of inflation and the decreasing purchasing power of the lempira over the past decade.

All five of the RFRM exemptions are considered problems in operating the UFSs. The most often cited one was the exemption for MOH employees' family members, mentioned by 61 percent of respondents. Considered together, the exemptions are probably seen as a problem for three reasons: (1) because they reduce potential income and (2) because some of them require the exercise of discretion, which may result in the perception of there being a lack of transparency and (3) because they make it difficult to enforce payment by some when so many are exempted and thereby compromise the integrity and transparency of the system. It is likely that this is why the fourth ranking problem, the exemption provided for MOH employees' family members, is so commonly regarded as a problem, and why all of the exemptions—even the exempting of indigents—are regarded as problematic. (This interpretation, as will be seen shortly, is also suggested by the open-ended responses.) It is probably not that Hondurans think that all exemptions should be eliminated. Rather, probably more at issue is how the exemptions impact the system's ability to achieve adequate cost recovery and to operate a fair and transparent user fee system.

Table 63
Facility Interviewees' Identified Problems With the *User Fee Regulation and Manual*
Responses to Close-Ended Questions
Includes Only Institutional and Mixed UFSs Who Feel the RFRM Needs to be Revised
Multiple Responses Were Possible

	Problematic Aspects of the User Fee Regulation and Manual	Number	Percent of Facilities	Percent of Responses
1	Purchasing restriction: Required to have 3 quotes for purchases > 100 lempiras	100	89%	17%
2	The ceiling of 2,000 lempiras on user fee revenue rotating funds	71	63%	12%
3	The ceiling of 1,500 lempiras in medicine purchases without being required to to obtain a quote from the Central Store of Medicines	68	61%	11%
4	The exemptions for MOH employees' family members	68	61%	11%
5	The requirement that revenues be deposited exclusively in state banks	54	48%	9%
6	The prohibiting of the sale of services to the private sector	54	48%	9%
7	The consultations that the MOH prohibits charging for	52	46%	9%
8	The exemptions for active community health personnel	48	43%	8%
9	The exemptions for MOH employees	46	41%	8%
10	The exemptions for indigents	39	35%	6%
11	Other	4	4%	1%
	Total	604	112	100%

There is a need for the MOH to review its user fee exemption policy in order to better define, justify and make well-known universal criteria and procedures for exemptions so as to make them better understood, more acceptable and more transparent. The application of new or re-affirmed criteria can still involve the exercise of local discretion (to enable the exercise of decentralized authority), but local MOH officials need the help provided by having a clearly defined and widely known set of exemption criteria to aid them in promoting and protecting the integrity of user fee systems.

It is important to note that while exempting MOH employees' family members is a common practice, it is not an RMRF-stipulated exemption. Owing to the vagueness of the definition of what the RFRM refers to as all "community health personnel" who are to be exonerated from payment, it is also not clear if the exempting of MOH employees is actually called for by the *Regulation* or if this phrase is intended to only include the cadre of public health volunteers. The practice of exempted MOH employees is regarded by 39 percent of the facility interviewees as a problem. **There is a need to more unambiguously define the categories of persons that the MOH wants, as a matter of policy, to exonerate from payment. This should be one of the topics addressed in the proposed review of user fee systems.**

7.3 What are the Key Problems of the Institutional UFSs? Open-Ended Questions and Proposed Solutions

7.3.1 MOH Facility Interviewees' Responses

Table 64 presents the identified RMRF problems rank ordered by top priority (in the upper portion of the table, labeled "A") and rank ordered by total responses (in the lower portion). The three top responses are identical in both orderings.

Graphs 48 and 49 present summaries of the responses to the open-ended question about what are the most important problems of the institutional UFS. Table 65 presents the detailed responses. The responses are those of interviewees working in facilities with either institutional or mixed systems. Multiple responses were possible. The former table shows the distribution of the percent of all responses, while the latter shows the percent of all facilities. The most common response, accounting for half of all responses, identified one or more RFRM-imposed restrictions. This response was given by 60 percent of the 104 respondents. The second most common response category indicated that the problem involved some type of operating procedure or way in which the UFS was managed, independent of RFRM-imposed regulations.

Table 66 contains the responses by Region. In six of the regions the most commonly cited problem is RMRF restrictions. In five of the regions this was the response of more than 70 percent of the facilities. The only other response category that was indicated by at least half of the facilities of any region were transparency--identified by 67 percent of the facilities in Comayagua and accounting for half of all of the transparency responses—and operating procedures/management, in Choluteca.

Table 67 shows the responses to the open-ended questions by type of facility. The likelihood that RMRF restrictions are identified as a problem is inversely related to the level of the facility. Eighty-six percent of hospitals regard them as a problem, compared to 64 percent of CESAMOs and only 24 percent of CESARs. This probably reflects the fact that all facilities, regardless of how much user fee revenue they generate and spend, are subject to the same limitations. The hospitals, which generate and spend much larger sums of UF revenues compared to the other types of facilities, are likely to

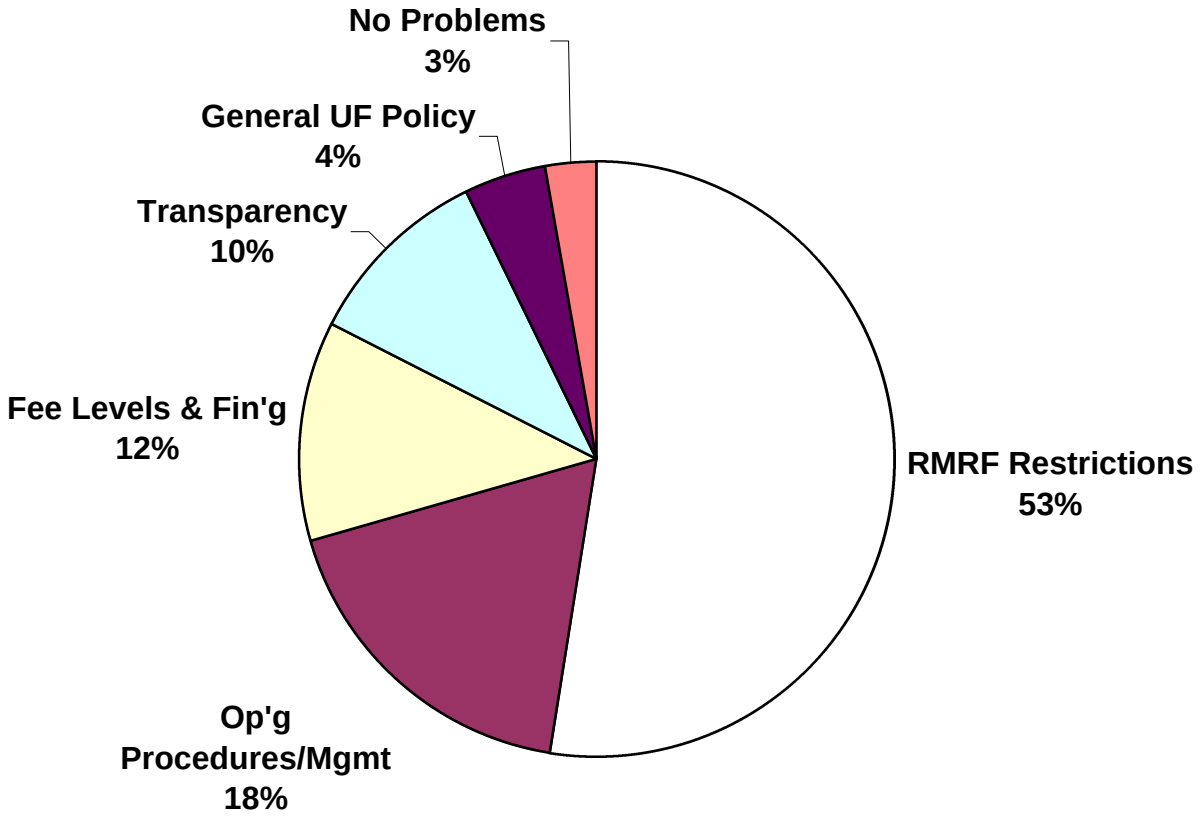
Table 64
Interviewees' Perceived Problems with the MOH User Fee Regulation and Manual, With Priority Rankings for Reforming the Identified Problem Areas
Includes Responses of Only Respondents with Institutional or Mixed UFS

A. Rank Ordered by Top Priority

		Top Priority		*Secondary Priority*		*Total Responses*	
	Problematic Aspects of the User Fee Regulation and Manual	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
1	Purchasing restriction: Required to have 3 quotes for purchases > 100 lempiras	99	23%	1	0%	100	23%
2	The ceiling of 1,500 lempiras in medicine purchases without being required to obtain a quote from the Central Store of Medicines	60	14%	8	2%	68	16%
3	The ceiling of 2,000 lempiras on user fee revenue rotating funds	59	14%	12	3%	71	17%
4	The requirement that revenues be deposited exclusively in state banks	46	11%	8	2%	54	13%
5	The consultations that the MOH prohibits charging for	34	8%	18	4%	52	12%
6	The exemptions for active community health members personnel	31	7%	17	4%	48	11%
7	The exemptions for indigents	30	7%	9	2%	39	9%
8	The exemptions for MOH employees' family members	25	6%	43	10%	68	16%
9	The exemptions for MOH employees	21	5%	24	6%	45	11%
10	The prohibiting of the sale of services to the private sector	20	5%	34	8%	54	13%
11	Other	3	1%	2	0%	5	1%
	Total	428	100%	176	41%	604	141%

Graph 48: Key Problems of the Institutional User Fee Systems

Percent of Responses, Multiple Responses By a Facility Were Possible



Graph 49: Key Problems of the Institutional User Fee Systems

Percent of Facilities Identifying as a Key Problem, Multiple Responses Were Possible

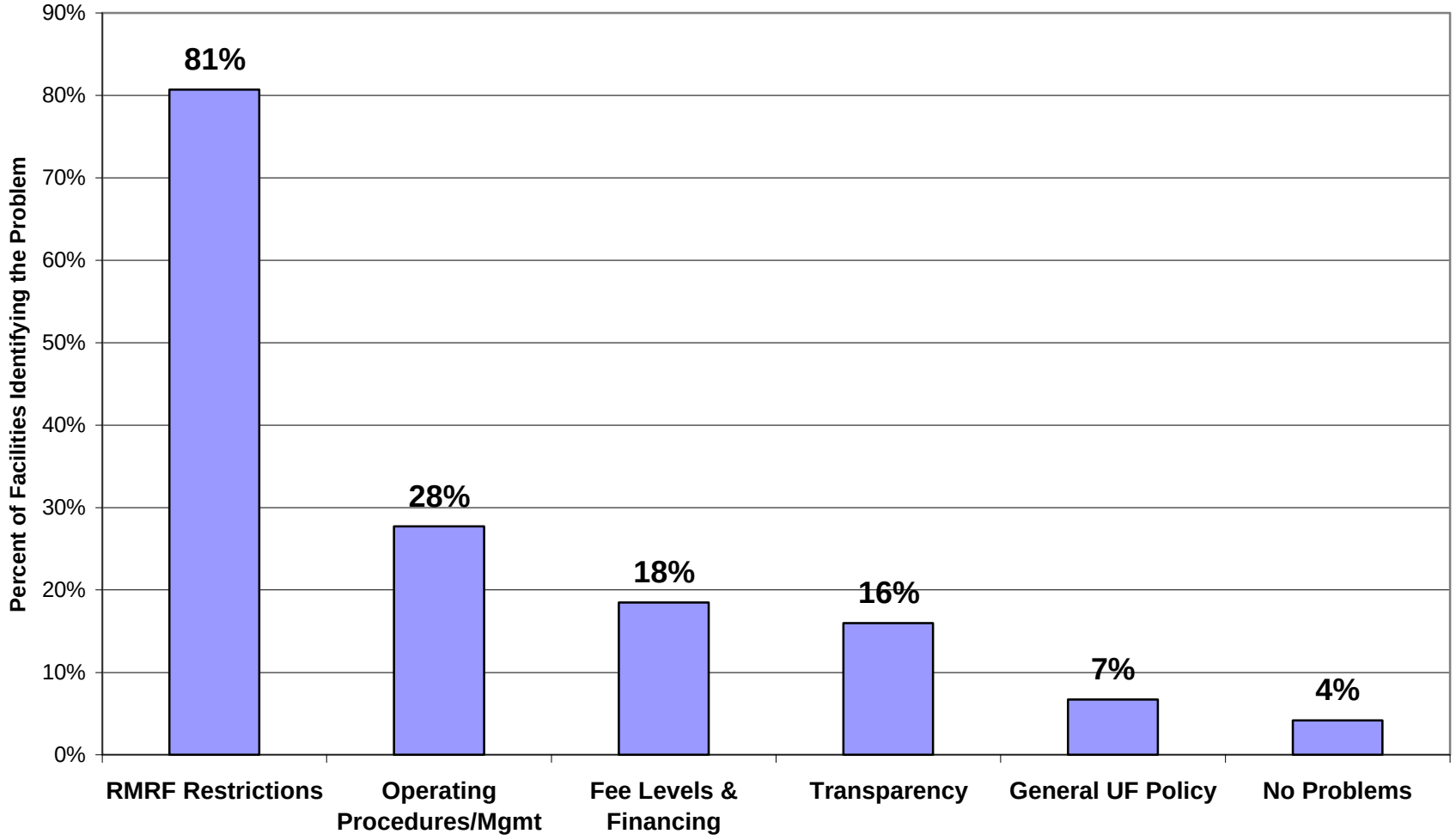


Table 65
Responses to Open-Ended Questions About What the Interviewees Regard as the Key Problems of the User Fee Systems

Includes All Institutional and Mixed User Fee Systems
Multiple Responses Possible

	Problem	*User Fee Systems*		*Responses*	
		Number	Percent	Number	Percent
A.	***RMRF RESTRICTIONS***	**72**	**61%**	**101**	**53%**
1	Regulations for purchases and quotes	23	19%	23	12%
2	The share going to the Reg'l Office	20	17%	20	10%
3	Allowed cash fund is too small, can't be counted on	13	11%	13	7%
4	Absence of updated RFRM	12	10%	12	6%
5	Ceiling for purchases is too low	10	8%	10	5%
6	Funds are not easily available	9	8%	9	5%
7	Restriction of contracting personnel	5	4%	5	3%
8	Exonerations	5	4%	5	3%
9	State Bank monopoly	4	3%	4	2%
10	RFRM is very rigid	2	2%	2	1%
B.	***OPERATING PROCEDURES / MANAGEMENT***	**33**	**28%**	**33**	**17%**
11	Lack of support from the MOH	13	11%	13	7%
12	No user fee cashier designated	9	8%	9	5%
13	Inadequate supplies of Treasury receipts	3	3%	3	2%
14	Too complex: Too many copies, too many places	3	3%	3	2%
15	Poor use of the funds	3	3%	3	2%
16	Absence of a social worker to orient patients	1	1%	1	1%
17	Inadequate support of Regional Office	1	1%	1	1%
C.	***FEE LEVELS AND FINANCING***	**24**	**20%**	**26**	**14%**
18	Inadequate financing for the UPS	12	10%	12	6%
19	Fee levels are very low	12	10%	12	6%
20	Need to improve the physical structure of the UPS	2	2%	2	1%
D.	***TRANSPARENCY***	**19**	**16%**	**19**	**10%**
21	Inadequate control for exonerations	12	10%	12	6%
22	Transparency problem	4	3%	4	2%
23	Lack of adequate supervision of the systems	3	3%	3	2%
E.	***THE RMRF / USER FEE POLICY IN GENERAL***	**8**	**7%**	**8**	**4%**
24	RFRM is unknown	4	3%	4	2%
25	No operationalization scheme for the RFRM	2	2%	2	1%
26	Lack of a UF policy	2	2%	2	1%

Table 66
Responses to Open-Ended Questions About What the MOH Facility Interviewees Regard as the Key Problems of Their Institutional or Mixed User Fee System
Number and Percent of Facilities with Institutional or Mixed UFSs

Region*	Number of Respondents	RMRF Restrictions	Operating Procedures / Management	Fee Levels and Financing	Trans-parency	RMRF and User Fee Policy in General	There are No Problems
Metropolitana	5	2 40%	1 20%	2 40%			1 20%
San Felipe	10	8 80%	3 30%	1 10%	3 30%	1 10%	
Comayagua	12	10 83%			8 67%	1 8%	
San Pedro Sula	19	14 74%	5 26%	5 26%	2 11%		2 11%
Choluteca	28	3 11%	14 50%	5 18%		2 7%	2 7%
Copan	15	12 80%		3 20%	1 7%	1 7%	
La Ceiba	14	10 71%	4 29%	3 21%	1 7%		
Juticalpa	3	2 0%		1 0%			
Puerto Lempira	1		1 100%				
All Regions	**107**	**65** 61%	**30** 28%	**21** 20%	**16** 15%	**5** 5%	**5** 5%

Table 67
Responses to Open-Ended Questions About What the MOH Facility Interviewees Regard as the Key Problems of Their Institutional or Mixed User Fee System
Number and Percent of Facilities with Institutional or Mixed UFSs

Type of Facility	Number of Respondents	RMRF Restrictions	Operating Procedures / Management	Fee Levels and Financing	Trans-parency	RMRF and User Fee Policy in General	There are No Problems
National Hospital	6	5 83%	4 67%	1 17%	1 17%	2 33%	0 0%
Regional Hospital	6	6 100%	1 17%	1 17%	2 33%	1 17%	0 0%
Area Hospital	16	13 81%	6 38%	1 6%	4 25%	1 6%	0 0%
All Hospitals	28	24 86%	11 39%	3 11%	7 25%	4 14%	0 0%
CESAMOs	66	42 64%	8 12%	15 23%	9 14%	2 3%	5 8%
CESARs	25	6 24%	14 56%	2 8%	2 8%	2 8%	0 0%
All Facilities	**119**	**96** 81%	**33** 28%	**22** 18%	**18** 15%	**8** 7%	**5** 4%

find those restrictions more confining and cumbersome. More hospitals indicated a larger number of different types of problems. The second most common problem identified by hospitals was operating procedures/management (39 percnt), followed by transparency (25 percent).

There was some divergence from the most frequently cited problems of the hospitals among the CESAMOs and CESARs. Among CESAMOs, while the predominance of the RFRM problem dwarfed all other responses, just as it did in the hospitals, the second most common problem was fee levels and financing, identified by 23 percent. The CESARs' responses were the most unique. Only a quarter of the CESARs, identified the RFRM as a problem, and it was only the second most common problem. The CESARs most frequently reported problem was operating procedures/management, identified by 56 percent.

After asking what the respondents regarded as the most important UFS problems they were asked what they thought could be done to resolve the problems. Multiple responses were again possible. The 119 institutional and mixed systems' respondents suggested 153 solutions. The most common response was a general call to reform or update the RFRM, which comprised 27 percent of all responses and was mentioned by 41 percent of the respondents. Among this and the 10 other responses three general themes could be identified:

- reform the RFRM, which included both general calls for reform, (such as noted above), or calls to reform specific, individual RFRM regulations,
- improve how the UF systems are operated, and
- the need for more resources (or the financing shortfall) plaguing many facilities.

Changing the RFRM was by far the most common solution proposed. It accounted for 74 percent of the suggestions. The other two general themes were mentioned 26 and 14 times, 17 and 9 percent of proposals, respectively.

Table 68 contains the facility respondents' proposed solutions to the IUFS problems they identified. Nearly three-quarters of the responses were related to the RFRM. They ranged from the general "reform" or "update" the *Regulation,* to calling for modifications of one or more of the specific regulations. The most commonly cited specific regulation respondents called for changing was the requirement that 25 percent of the facility's revenues be given to the regional office.

7.3.2 The Regional Office Responses

All nine of the regional office (RO) representatives indicated that there were various stipulations set forth in the RMFR that they believe impedes the use of the institutional user fee revenues. Table 69 shows the interviewees' responses. All nine identified the 100 lempira maximum purchase that can be made without being required to obtain three price quotes as an impediment. When asked more specifically to identify the most important problems in the institutional user system (IUFS), five of the interviewees identified this particular requirement.

Returning to Table 69, one can see that more than half of the regional office respondents identified at least eight different specific ways in which the RMFR impedes the use of user fee revenues. Clearly, the RMFR is regarded as out-of-date and a major source of unnecessary and/or ineffective bureaucratic procedures. The most commonly cited among the "important problems" of the IUFS (beyond the 100 lempira maximum) are: the lack of an updated RMFR, the low level of fees

Table 68
MOH Facility Interviewees'
Proposed Solutions to the Problems of the Institutional User Fee Systems
Responses to an Open-Ended Question

Multiple Responses Possible, 99 Institutional UFS respondents

	Proposed Solution*	Responses		Percent of UF Systems
		Number	Percent	
A. RFRM-Related				
1	Reform/Update the RFRM	41	27%	41%
2	All revenues should be retained by the UPS	29	19%	29%
3	Reform purchasing regulations	18	12%	18%
4	Reform the RFRM-establish new legal framework	11	7%	11%
5	Modify hiring prohibition / allow paying cashiers	7	5%	7%
6	Increase the 2,000 lempira ceiling on the UPS rotating fund	4	3%	4%
7	Allow deposit of revenues in private banks	3	2%	3%
	RFRM-Related Total:	**113**	**74%**	
B. Changing How the UFS Operates or is Managed				
8	Revise and more closely monitor exemptions	15	10%	15%
9	Make fee levels more comparable, equitable	5	3%	5%
10	Increase fee levels	6	4%	6%
	Operations / Management Total:	**26**	**17%**	**26%**
C. Allocating More Resources/Greater Financing Levels				
11	Give more attention to the facilities' needs	**14**	**9%**	**14%**
	Total:	**153**	**100%**	**99**

Table 69
Regional Office Representatives' View of Elements of the Institutional *User Fee System Regulation and Manual* that Impede the Use of Generated Revenues

(Nine Interviewees, Interviewees May Have More Than One Response)

Impediment	Number of Respondents	Percent of Respondents
1. The 100 lempira maximum purchase that can be made without being required to obtain three quotes	9	100%
2. The requirement that revenues must be deposited in state banks	8	89%
3. The consultations that must all be provided free-of-charge	8	89%
4. The exonerations that are provided to MOH employees	6	67%
5. The 1,500 lempira maximum on purchases of medicines without being required to obtain a quote from the Central Medicine Warehouse, MOH	6	67%
6. The 2,000 lempira maximum allowed Rotating Funds	5	56%
7. The exonerations that are provided to indigents	5	56%
8. The exonerations that are provided to MOH employees familiy members	5	56%
9. The exonerations that are provided to active community personnel	4	44%
10. Not being able to use a private bank	1	11%
Total responses	57	

(prices), the lack of controls and poor management of the funds by the UPSs and the lack of socio-economic studies to determine patients' capacity to pay.

Table 70 presents the Regional Office respondents' proposed solutions to what they regard as the key problems of the ISs. It is noteworthy that the question about what they regarded as the key problems, as well as what they thought possible solutions to them were both open-ended questions. The most common proposal is to periodically increase user fee levels to take into account inflation, presumably with the goal of maintaining real fee levels. This was the response of two-thirds of the ROs. The only other change that was recommended by more than half of the ROs was to revise and update the Manual. One-third of the ROs suggested that the UPSs should be authorized to use their UF revenues, suggesting that these RO interviewees regarded the monitoring systems as unnecessary or ineffective.

7.3.3 The Community Health Board Representatives' Responses

The 82 community health boards were asked what they thought were the main problems of the institutional UFS and of the community UFS. First we will look at their responses dealing with institutional UFSs. Seventy-nine percent of respondents said they did not know what were the problems of the institutional system. Again, a few individuals maintained that the system did not have any problems, and the remaining 15 identified specific types of shortcomings that are identified in Table 71. Three general, policy-relevant themes were discerned in these responses: general financing woes, difficulties related to stipulations in the Regulation, shortcomings related to the administrative capacity and the transparency of the system. The frequency of each of these responses is presented in the bottom portion of Table 71.

Table 72 presents the community health board representatives' proposed solutions to what they regard as the key institutional UFS problems. Nine of the 11 responses (82 percent) called for reforming the UF *Regulation*. There were six distinct proposals for doing so, however, and none of them were cited by more than two respondents. The various requirements of the *Regulation* are regarded differentially as being an obstacle to the effective management and operation of the institutional UFSs. Thus among those who feel the institutional UFSs have problems and identify specific problems, while there is a consensus that the *Regulation* is encumbering, there is no consensus as to what provisions of it are the most onerous or about how best to go about improving the situation.

7.3.4 Municipal Government Interviewees' Responses

Table 73 presents what the municipal government interviewees regard as the key problems of the IUFS. Seventy-one percent responded that they did not know what the problems were. This was the same general magnitude of the proportion of the community health board interviewees' that so responded (71 percent). Only 20 percent of the 56 respondents identified a problem. Their responses were split about in half between RFRM-related problems and general financing problem. As with the community health board representatives so too here, the Regulation is regarded as the single most important problem impeding the effective functioning of the institutional UFSs.

Table 74 contains the municipal government interviewees' proposed solutions to what they identified as the key IUFS problems. Only 15 percent of the municipal government representatives made suggestions. The most common response was that the funds should stay in the facility and not

Table 70
Proposed Solutions to Institutional User Fee System Problems Identified by the Regional Offices Interviewees

(Nine Interviewees, Interviewees May Have More Than One Response)

Problem	Number of Responses	Percent Responses	Percent of Regional Offices
Adjust user fee levels to take into account inflation	6	32%	67%
Revise and update the manual	5	26%	56%
Authorize the UPSs to use the funds	3	16%	33%
Better justification of exonerations	2	11%	22%
Train and adjust salaries of UPS personnel	2	11%	22%
Undertake socioeconomic studies of patients' abilities to pay	1	5%	11%
Total	19	100%	

Table 71
Institutional User Fee System Problems
Reported by the Community Health Board Interviewees

Response	Number of Health Committees	Percent of Responses
1. Don't know	69	79%
2. Having to take the funds to the Regional Office	5	6%
3. There aren't any problems	3	3%
4. Too few funds are allocated to the UPS	3	3%
5. The steps required in orer to make purchases	2	2%
6. The use of the funds not adequately supervised/monitored	2	2%
7. The long duration of the reimbursement process	1	1%
8. The high cost of, and time required to fill out, receipts	1	1%
9. The slowness in allocated necessary resources to the UPS	1	1%
Total	87	100%

Identified Problems

1. General Financing (4,9 above)	4	27%
2. RMFR Reform-Related (2,5,7,8 above)	9	60%
3. Administrative Capacity / Transparency (6 above)	2	13%
Total:	15	100%

Table 72
Proposed Solutions to Institutional User Fee System Problems Identified by the Community Health Board Interviewees

Problem	Number of Health Committees	Percent of Responses
Eliminate the requirement that UPSs have to carry the funds to the Regional Office	2	18%
Develop user fee regulations / controls	2	18%
Make the UPS's management of the funds more flexible	2	18%
Make the regulations/required steps simple and fast	1	9%
All funds should be assigned to/left with the UPS	1	9%
Assign a cashier/supervisor to manage the funds in the UPS	1	9%
Make changes for the benefit of the UPS	1	9%
Do not make unnecessary expenditures	1	9%
Total	11	100%

Table 73
Institutional User Fee System Problems
Reported by the Municipal Government Interviewees

Responses	Number of Mayoral Offices	Percent of Responses
Don't know	40	71%
There aren't any problems	3	5%
There is no institutional user fee system	2	4%
Identified Problems	**11**	**20%**
1. General Financing (Cannot pay for the needs of the UPS. Too few funds are allocated to the UPS)	5	9%
2. RMFR-Reform Related (Having to take the funds to the Regional Office. There is no updated regulation)	5	9%
3. Administrative Capacity / Transparency (The physician manages the funds and does not inform the community)	1	2%
Total	56	100%

Only Those Who Had Views	Number of Mayoral Offices	Percent of Responses
A. No Problems	**3**	**21%**
B. Identified Problems	**11**	**79%**
1. General Financing	5	36%
2. RMFR Reform-Related	5	36%
3. Corruption-Related	1	7%
Total	**14**	**100%**

Table 74
Proposed Solutions to Institutional User Fee System Problems Identified by the Municipal Government Interviewees

Problem		Number of Mayoral Offices	Percent of Responses
The funds should stay in the UPS to solve its problems		4	44%
Develop an updated and more specific user fee regulation		1	11%
More funds should be assigned to the UPS		1	11%
Assign a cashier to manage the funds in the UPS		2	22%
Work with the personnel of the UPS to find a solution		1	11%
	Total	9	100%

Source / Characterization of Problem			
General financing shortfalls		1	11%
Need to change the User Fee Manual (RMFR)		5	56%
Structural / Operational problems		3	33%
	Total	9	100%

have to go to and be shared with the regional office. The call for RFRM reforms constituted 56 percent of the suggestions.

7.4 What are the Key Problems of the Community UFSs? Responses to an Open-Ended Question and Proposed Solutions

7.4.1 MOH Facility Interviewees' Responses

The CSs' identified key problems are presented in Table 75. Forty-four percent of the CS respondents said that their community UFS had no problems. This was the single most common response, and may be compared to the much smaller proportion, just three percent, of IS respondents who said their institutional system had no problems. The only other common response, indicated by 19 interviewees, was "inadequate general financing and support." Most of these responses (13 of the 19) identified the lack of medicines, the lack of income or the need for more financial assistance from the regional and/or central office.

Thirty-four interviewees offered solutions to what they perceived as the major problems of CSs. See Table 76. The most common of the 11 suggested solutions was to train the health committee members, suggested by 15 percent. Twenty-nine percent of the responses did not actually suggest changes for CSs, but rather consisted of suggestions for overcoming their facility's financial shortfalls or other resource problems, which apparently were the primary factors motivating the establishment of these CSs. These suggestions included

- hire more personnel,
- impove the physical structure of the facility and
- purchase medicines.

If these are eliminated from the analysis, the 24 remaining responses carry two major themes with considerable overlap: (1) improve health committee-facility coordination and communication, and (2) improve the accountability and transparency of the system.

7.4.2 Community Health Board Representatives' Responses

Table 77 contains what the health board representatives believe to be the key problems of the community UFSs. Relative to the institutional systems, a much larger proportion of the respondents stated that the community system does not have any problems; 35 percent compared to just 3 percent for the institutional systems. It is important to consider the source of the responses, the health committees. As the administrators of these systems, it is reasonable to expect that at least some of them are likely to be defensive about "their" systems and to deny that they have any problems. Another 20 percent responded that they didn't know what the problems were. The remaining 45 percent of responses identified 14 problems. Again, common themes of the responses were identified and the responses were classified into one of four more policy-relevant categories, which are presented in the bottom portion of Table 77. Problems of coordination among authorities and the politicization of the UFS was cited by 33 percent of respondents with a specific identified problem, and was the most commonly cited problem of community systems. The other three categories were also frequently cited. Thus problems or the source of problems were not nearly as uni-dimensional as

Table 75
What MOH Facility Interviewees
Regard as the Key Problems of Their Community User Fee System
Responses to An Open-Ended Question
Multiple Responses Possible, 66 Respondents

Problem or Shortcoming	Number of Responses	Percent of Responses	Percent of Facilities
1 There are no problems	29	41%	44%
2 Inadequate general financing and support	19	27%	29%
3 Transparency related	7	10%	11%
4 Health Committee doesn't inform UPS of income or expenditures	6	9%	9%
5 Health committee has inadequate control of the system	5	7%	8%
6 Inadequate control for exemptions / exonerations	2	3%	3%
7 Lack of established UF procedures / a formal policy	2	3%	3%

Table 76
MOH Facility Interviewees'
Proposed Solutions to the Problems of the Community User Fee Systems
Responses to an Open-Ended Question

Multiple Responses Possible

	Proposed Solution	Responses		Percent of UF Systems
		Number	Percent	
1	Train the health committee members	5	15%	14%
2	Require the Health Committee to regularly report income and expenditures	4	12%	11%
3	Attempt to secure aid from local patrontos	3	9%	8%
4	Select health committee members with good reputations	3	9%	8%
5	Health Committee personnel should be more responsible	3	9%	8%
6	Improve comunication with the UPS	2	6%	5%
7	Elect a new Health Committee	2	6%	5%
8	The user fee revenues should remain in the UPS	2	6%	5%
	Inappropriate Responses: Not Solutions to Community UFS problems			
9	Improve the physical structure of the facility	4	12%	11%
10	Purchase medicines	4	12%	11%
11	Hire more personnel	2	6%	5%
		34	100%	

Table 77
Community User Fee System Problems
Reported by the Community Health Board Interviewees

Responses to an Open-Ended Question

Response	Number of Health Committees	Percent of Responses
1. There are no problems	31	35%
2. Don't know	18	20%
3. Funds are insufficient to cover needs	8	9%
4. Irresponsible acts by the members of the health committee	6	7%
5. The lack of support from the authorities	5	6%
6. Persons with poor reputations were assigned to run the system	4	5%
7. Lack of communication from the MOH with health committees	3	3%
8. There is little knowledge about health	3	3%
9. Not everyone wants to pay the established fee	2	2%
10. Lack of unity	2	2%
11. There are transportation problems	1	1%
12. Dependent upon the Regional Office which doesn't support the UPS	1	1%
13. The UPS cannot dispose of the Funds	1	1%
14. There are no reports about revenues or expenditures	1	1%
15. The committee does not manage the funds	1	1%
16. The lack of accounting capacity	1	1%
Total:	88	100%

Identified Problems

1. Coordination / Politicization (5,7,10,12,13,15 above)	13	33%
2. Administrative Capacity / Transparency (4,6,14,16 above)	12	31%
3. General Financing (3 above)	8	21%
4. Other (8,9,11 above)	6	15%
Total:	39	100%

was the case with the institutional systems and the *Regulation*. It is interesting to note that nearly 14 percent of the health committee respondents—that is, the people who are involved in administering the community systems—identified administrative capacity / transparency as an important shortcoming of these systems. Limited to those who identified a specific problem, those 12 responses represent 31 percent of all responses.

The community health board interviewees' proposed solutions to the problems they identified are presented in Table 78. The individual responses are rank-ordered in the top portion of the table. In the bottom portion, the responses are re-organized into policy-relevant categories. Most of the responses fall into the "structure/operations" category, which captures problems that arise from the way in which the current system is structured or operates—independent of the RFRM-imposed regulations—and which are potentially amenable to change if the MOH or some other central government agency established some common operating procedures. This category accounts for half of the responses.

7.4.3 Municipal Health Committee Representatives' Responses

Table 79 presents what the municipal health committee representatives view as the key problems of the community UFSs. Their proposals for improving the CSs (see Table 80) are more diverse, reflecting the greater breadth of problems identified with the community systems. Whereas coordination and politicization were identified as the chief problem among the community UFSs, only 13 percent of the specific proposals for change addressed this concern. In contrast, a disproportionately large share of suggestions (45 percent) called for changes that improve administrative capacity or transparency. This imbalance is probably due to the easier to identify and more discrete types of solutions that this second category of problems lends itself to, relative to the first. The other two categories of solutions, general financing and other, account for roughly equivalent shares of identified problems and proposed solutions.

Over half of the proposals could be addressed by providing a more formal and structured framework by establishing and operating community systems. Rules could be established for selecting persons administering the systems as well as for accounting systems to ensure the integrity of the funds. In addition, system personnel and the general public could be educated and trained in how the system functions. These steps could be made without infringing on the local control of the disposition of the funds garnered in community systems. If a substantial proportion of the people operating these systems think they lack administrative capacity and transparency, it is likely that the general public has the same perception. Improving the public's general regard of the system would likely make people more willing to pay user fees and to pay higher fees.

The level of satisfaction among the health facility and community health board respondents with community UFSs is significantly greater than it is with institutional systems. Forty-four percent of facility respondents and 35 percent of community health board respondents reported that their CS did not have any problems, compared to only five and three percent, respectively, of those asked about their institutional UFSs. Municipal governments widely admit to not being aware of what are the problems of either of the two systems. For both systems about 70 percent of the municipal government representatives stated they did not know what are the UFS's problems. This is an interesting observation in light of the fact that 58 percent of them provide some type of support to one or more MOH facility.

Table 78
Proposed Solutions to Community User Fee System Problems Identified by the Community Health Board Interviewees

Responses to Open-Ended Questions

Problem	Number of Health Committees	Percent of Responses
Select persons with good reputation to run the system	8	20%
Health authorities should provide greater economic support	6	15%
Provide training in health	5	13%
The funds should remain in the UPS	4	10%
Increase the fee levels	4	10%
The revenues should be "fiscalizado" (officially monitored by the Treasury Ministry)	4	10%
Increase communication	3	8%
Educate the community in the importance of paying the fees	2	5%
Give power to another association	1	3%
Motivate the committee to be more active	1	3%
provide means of transportation	1	3%
Don't know	1	3%
Total	40	100%

Common Themes		
Structure / operations	24	60%
RFRM-related	8	20%
General Financing	6	15%
Other/Don't know	2	5%

Table 79
Community User Fee System Problems
Reported by the Municipal Government Interviewees

Responses to an Open-Ended Question

Response	Number of Mun. Gov't Representatives	Percent of Responses
Don't know	38	69%
There aren't any problems	5	9%
There is no community user fee system	4	7%
Identified Problems	**8**	**15%**
1. General Financing (The fee levels are very low)	2	4%
2. RMFR Reform-Related (There is no up-to-date Regulation)	1	2%
3. Corruption-Related (There isn't adequate control of the funds. Persons with poor reputations run the system. There are no reports about revenues or expenditures.) system.)	4	7%
4. Other (There is no cashier for the system.)	1	2%
Total	55	100%

Only Those Who Had Views	Number of Mun. Gov't Representatives	Percent of Responses
A. No Problems	**5**	**38%**
B. Identified Problems	**8**	**62%**
1. General Financing	2	15%
2. RMFR Reform-Related	1	8%
3. Administrative Capacity / Transparency	4	31%
4. Other	1	8%
Total	**13**	**100%**

Table 80
Proposed Solutions to Community User Fee System Problems Identified by the Municipal Government Interviewees

Responses to an Open-Ended Question

Problem	Number of Mun.Gov't Representatives	Percent of Responses
Assign a cashier for the system	1	20%
Select persons with good reputation to run the system	1	20%
The revenues should be "fiscalizado" (officially monitored by the Treasury Ministry)	1	20%
The UPS together with the community should manage the funds	1	20%
Increase the fee levels	1	20%
Total	5	100%

7.5 Opinions about a Specific Proposal for Restructuring the ISs

Table 81 shows the reactions of the MOH facility interviewees' to the proposal for supplanting the regional offices' role as the supervisors of the institutional UFSs with the municipal government. The most common response was "Functions that do not correspond to the municipal government cannot be assigned to it." This legalistic, status quo-based response, may be translated as ultimately meaning "no;" i.e., the respondent is not in agreement with, or supportive of, the proposal. Still, if there were a public discussion of this proposal where central government officials made it clear that this possibility was being considered, it would require 81 percent (22) of these 27 respondents to say they would support such a proposal just to achieve the same proportion of persons that are opposed to it. When it is added to the other, more straightforward negative responses, they constitute 68 percent of the total.

The Regional Office interviewees' opinions were surprisingly positive. See Table 82. The nine interviewees offered 11 responses. Nearly two-thirds of the respondents thought the proposal had merit. The major source of reluctance was the fear that the system would become too politicized.

The health committee interviewees responses are shown in Table 83. In general, they were negative, with 55 percent of the 82 respondents expressing disagreement and another 16 percent uncertain. Only 21 percent expressed unqualified support and another 9 percent qualified their responses with some type of caveat or condition. These responses suggest that at present most health committees operate largely independent of their municipal governments.

The Regional Office interviewees were also asked if they thought the institutional UFS should be eliminated and only community systems maintained. As may be seen in Table 84, there were no unambiguously supportive reactions to this proposal. It appears that the RO representatives believe that some type of oversight of UFSs is necessary.

Table 81
MOH Facility Interviewees' Reactions to a Proposal to Supplant the Regional Offices' Supervisory Role in Institutional User Fee Systems with the Municipal Government

Responses of Facilities with Institutional UFSs to an Open-Ended Question

Open Ended Responses	Number	Percent
1 Cannot assign such functions to the Mun.Gov. that don't correspond to it	**27**	26%
2 No, do not think it is a good idea	**44**	**42%**
Mun.Gov. does not have admin. capability	8	8%
Too bureaucratic, too political	14	13%
Prefer to continue with the regional office	16	15%
Mun.Gov. would use income for things other than the health facility's needs	6	0% 6%
3 Yes, think it is a good idea	**27**	**26%**
Its closer to the facility than the reg'l office	6	6%
They'd have to be trained and oriented	3	3%
They'd have to have health experts	3	3%
All other yes	15	14%
4 Not sure / Don't know	**6**	**6%**
TOTAL:	**104**	**100%**

Table 82
Regional Office Representatives' Views of the Desireability of The Mayor's Office Assuming the Regional Health Office's Role As the Supervisor of the Local UPSs' Institutional User Fee System

(Nine Interviewees, Interviewees May Have More Than One Response)

Detailed Responses	Number of Responses	Percent of Responses	Percent of Regional Offices
Yes, In Agreement, Unqualified Support	**4**	**36%**	**44%**
Excellent, it would not affect the network	3	27%	33%
Because the Mayor's Offices supports the UPS	1	9%	11%
Yes, In Agreement, But Qualified			
But there would have to be an investigation of their technical, administrative capacity	**3**	**27%**	**33%**
No, Not in Agreement			
Too highly politicized	**2**	**18%**	**22%**
The norms and laws of public administration do not permit it	1	9%	11%
Because the Mayor would intervene in the Region	1	9%	11%
Total:	11	100%	

Summarized Responses	No. of Reg'l Offices' First Responses	Percent of Reg'l Offices' First Responses
In Agreement (Yes)	6	67%
Disagree (No)	3	33%
Total:	9	100%

Table 83
Health Committee Representatives' Views of the Desireability of The Mayor's Office Assuming the Regional Health Office's Role As the Supervisor of the Local UPSs' Institutional User Fee System

Response	Number of Health Committees	Percent of Health Committees
No, do not agree	42	51%
There doesn't exist any system for doing so	2	2%
The Municipality would make bad use of the funds	1	1%
Don't know	13	16%
Yes, I agree	17	21%
The committee would obtain the funds	3	4%
Yes, if both the Municipality and the UPS would administer it	1	1%
Both should know the income of the UPS	2	2%
The Municipality supervises but doesn't control the use of the funds	1	
Total	82	100%

Summary

In Agreement		
Unqualified	17	21%
Qualified*	7	9%
Total	24	29%
Disagree	45	55%
Don't know / Uncertain	13	16%
Total:	82	100%

Table 84
Regional Office Representatives' Views of the Desireability of Eliminating the Institutional System and Maintaining Only the Community User Fee System

	Number of Regional Offices	Percent of Regional Offices
Then it would become a Mixed System	3	33%
No, it should be maintained for the coverage	2	22%
There would be irregularities (embezzling) in the health sector	2	22%
Excellent, but the Region should be the Regulator	1	11%
That implies defining a new system	1	11%

8. A Review of Key Findings, Discussion and Recommendations

This chapter starts with a review of the key findings of this study. The following section synthesizes these findings and combines this analysis with other considerations to forge an interpretation of the last decade; what has happened in user fee systems and why. The final section takes a more future-directed view of the system, and considers how the MOH might modify its approach to user fee systems as a means to get more in-step with the general plans of the GOH in moving the country toward a more participatory and decentralized society.

8.1 A Review of the Key Findings

1. The Numbers and Types of UFSs

1.1. Seventy-nine percent of MOH facilities have a UFS.

1.2. Thirty-three percent of the UFS are institutional systems, 54 percent community systems and 13 percent mixed (combinations of institutional and community) systems.

1.3. The definition of what constitutes a user fee system and what distinguishes an institutional from a community system are not always clear-cut and unambiguous. The primary reason for the ambiguity is the general ignorance about the *Regulation and Manual for Recovered Funds,* the law which distinguishes institutional and community systems. Another contributing factor is that the Regulation defines a community system as one which is established and managed by a community health board. Once established, many community UFSs come to be managed exclusively by health facility personnel, making it the status of the UFS uncertain.

1.4. All 29 hospitals have institutional user fee systems.

1.5. Ninety percent of CESAMOs have a UFS, and 63 percent of their UFSs are institutional systems.

1.6. Seventy-six percent of CESARs have a UFS, and 74 percent of their UFSs are community systems.

2. The Regional Office Supervisory and Monitoring Systems

The RMRF establishes the regional offices as the hub of UFSs and delegates them major authority to supervise and monitor UFS operations. The supervisory, monitoring and reporting systems that the regional offices have developed vary considerably. Some are well aware of the operations of the UFSs throughout their region, others are loosely structured and operate in a more haphazard manner. For instance, one regional office describes more than 80 percent of the institutional UFSs in its domain as “sporadic.” Another reports that nearly all of the UFSs in its domain are community systems, and

thus it is explained, it has little to do with UFSs. Few of what this respondent referred to as community systems, however, have a community health board, which is the legal *sine qua non* for a community system. As regional offices have no responsibility for monitoring community UFSs, it may be that the label "community UFS" is invoked as a means for eschewing the responsibility of monitoring institutional user fee systems.

3. Knowledge and Understanding of the RFRM

3.1. MOH staff's general level of knowledge about the RFRM is low. Only one-quarter of the surveyed facilities were aware of the *Regulation*, and only 22 percent had a copy of it. With such low levels of knowledge about the RFRM, it is highly likely that there are numerous and frequent violations in its regulations.[22]

3.2. Four of the nine regional offices are ignorant about their role in RFRM-established procedures for modifying prices. Three reported that the Regulation set fee levels and the fourth said the Central Office determines them. This is an important factor explaining why user fees have rarely been changed. Slightly more than half of the surveyed facilities have never changed their user fee levels since the UFS was first established, and those that have modified their prices have done so infrequently. Given the rate of inflation in Honduras over the past decade, constant or infrequently changing fee levels have resulted in falling real revenues and faltering cost recovery efforts.

4. Adherence to the RFRM

4.1. The RFRM states: "III. General Dispositions: 2. All MOH facilities will charge the established tariff for services that are provided to the public…with the exception of the centers in which function the community system." According to the UPEG inventory survey, 233 (21 percent) of MOH facilities do not have a user fee system.

4.2. The RFRM states: "The Health Centers (CESARs or CESAMOs) may operate a community system… through a community health board" (page 10). Only 82 percent of the health centers with a community or mixed UFS have a health board, and in only 62 percent of the centers with a board does the board supervise the user fee monies.

4.3. The RFRM states: "There will be no charges for the following services: prenatal care, growth and development, immunization, family planning, sexually transmitted diseases and tuberculosis" (page 11). Only 7 percent of the surveyed facilities provide all six of these services free-of-charge. National hospitals do not provide any of them free-of-charge, while CESARs most consistently adhere to the regulation. Ten percent of all of the free services provided were types of services that the RFRM does not stipulate should be free. Among CESAMOs and CESARs, community systems more consistently adhere to the official policy than do institutional systems.

4.4. The RFRM states: "Active members of the community personnel will be exempt from payment for health services" (page 11). Only about three-quarters of all facilities provide

[22] Although this study investigated non-compliance with the RFRM it did so on a general level with the goal of assessing whether or not MOH policy objectives were being upheld. The study was not intended to, and did not, examine irregularities in user fee revenue-related financial flows.

services free-of-charge to all community health volunteers, yet, at the same time, most facilities have extended free care to additional categories of persons not identified in the *Regulation*, including: MOH staff (75 percent of facilities provide them free care), family members of MOH staff (60 percent), health committee members (31 percent) and senior citizens (15 percent).

4.5. The RFRM states: "Persons that cannot pay totally or partially for the use of health services should still be attended" (page 11). None of the facilities surveyed have sliding fee scales (i.e., different fee levels or partial payment): people either pay the full established price or they are totally exempt from payment. Seventeen percent of the surveyed facilities reported they do not exonerate the poor from payment.

4.6. The RFRM states: "All of the institutional UFS revenues collected by CESARs and CESAMOs will be sent to the Regional Office, of which 25 percent of this total will be reserved for operations expenditures of the region and its network of facilities (page 6). The degree of compliance with this regulation varies by region. In one region only 29 percent of facilities report that they submit their institutional UF revenues to the region.

4.7. The RFRM states: "The hospitals should transfer 10 percent of their recovered funds to their corresponding regional office" (page 6). Less than one-third of the hospitals reported that they complied with this stipulation to share their revenues with the regional office. Only half of the regional hospitals and none of the national hospitals reported they did so. Two hospitals reported they just recently suspended the practice in the aftermath of Hurricane Mitch, when their financing needs became much more pressing.

5. User Fee Levels / Prices

5.1. User fee levels are low. The weighted average price of a general consultation in an institutional UFS is 2.0 lempiras.

5.2. The average price of a general consultation is equal to 0.07 percent of average per capita income.

5.3. Average prices in community UFSs are significantly higher than those of institutional UFSs in both CESAMOs and CESARs, 3.40 versus 1.93 and 3.05 versus 2.21, respectively.

5.4. Community UFSs, which are most commonly found in CESARs--where care is provided by a nurse auxiliary, have generally average prices than institutional UFSs, which are more commonly found in higher levels of facilities, where care is generally provided by a physician. While this study did not estimate the cost of care provision, it is highly likely that the cost of care provided by a nurse auxiliary in a CESAR with a community UFS is less expensive than that provided by a physician in a higher level of facility with an institutional system. Thus, users of CESARs are paying a more for less costly care, and thus paying a higher proportion of the cost of their care than are the users of the higher levels of care. This is inequitable from a "benefits-received" perspective of taxation.

5.5. Since the community UFSs (most of which are in CESARs) have higher average prices than institutional UFSs (found primarily in CESAMOs and hospitals), and since CESARs are generally located in more remote areas where incomes are likely to be lower, it is also

likely that the incidence of user fees is vertically inequitable; i.e., that poorer persons pay more in both absolute and relative (to income) terms.

5.6. Prices in general, and especially institutional user fees, have changed infrequently. More than half of the surveyed facilities have never changed their user fee levels since the system was first established. Among the systems that have changed their fee levels, the last time they did so, on average, was three years ago.

5.7. Fifty-one percent of the facilities that have never changed their user fee levels reported they had not modified them because the regional office had not given them the "okay" to do so. If the 19 percent who responded "don't know" are excluded from the denominator, 62 percent of the facilities identified the regional office as an obstacle to their changing their fee levels.

5.8. Four of the nine regional offices stated that prices in their respective regions have never changed because the RFRM does not permit them to change or because it is the central office that determines prices. These responses indicate ignorance about the authority and responsibility of the regional office in determining user fees, suggesting that regional offices may inadvertently be obstacles to increasing user fee levels.

5.9. On average, community UFS prices change more often and have been changed more recently than institutional UFS prices.

5.10. In the 78 facilities in which institutional user fee levels were increased at least once in the past four years, a facility-specific review of service delivery statistics found no evidence that the price increases deterred utilization.

5.11. Average institutional UFS prices vary across different types of facilities in such a way that it encourages would-be patients to use the pyramidal referral system inappropriately. Average fee levels in a CESAR are equal to the MOH average and higher than in a CESAMO, and they are higher in a CESAMO than in a national hospital. These use fee levels are providing the wrong signals to would-be patients.

5.12. There is variation in the number of different services for which distinct institutional user fees are charged both across and within different types of facilities. While CESARs have a single, all-inclusive fee, CESAMOs have an average of 11 different fees and area hospitals have 55, more than any other type of hospital.

5.13. There are large variations in the institutional user fees charged at different facilities of the same type for the same service. The average price charged for a general consultation is uniform at national hospitals, but vary by a factor of five in CESARs, CESAMOs and regional hospitals, and area hospitals' prices vary ten-fold.

5.14. According to data from the ENIGH survey, the likelihood of paying for an ambulatory acute curative care visit at an (any) MOH facility is 79 percent. The probability is highest for persons using CESARs, 89 percent, and lowest for those using a hospital, 49 percent. The relative rates at which persons are exempted from payment at the different levels of MOH care are encouraging the inefficiency of the Ministry of Health.

5.15. Average effective prices are equal to the probability of paying for care multiplied by the average price paid. Average effective prices in IUFSs are lowest at hospitals and highest

at CESARs, encouraging the inappropriate use of the MOH's pyramidal referral system, and thereby, increasing the inefficiency of the MOH. More services are demanded and provided at hospitals relative to the CESAMOs and CESARs than would be the case with a more appropriate price structure. This exacerbates congestion at the hospitals and CESAMOs and increases the costs of the MOH. This factor has probably contributed to (1) regional and area hospitals' average number of ambulatory care visits growing 47 percent faster than CESAMOs from 1995 to 1999 (22 versus 15 percent, respectively), and (2) the 35 percent increase in the share of all hospital ambulatory care that is provided in the emergency department over the same period (increasing from 23 percent in 1994-95 to 31 percent in 1997-98).

5.16. In 1999 the six services mandated by the RMRF to be provided free-of-charge constituted 35.4 percent of all ambulatory care visits provided by the MOH. This proportion has remained relatively constant over the past four years, suggesting that it has not been a factor explaining increasing user fee revenues.

6. Total Institutional User Fee Revenues Generated

6.1. In 1999 total institutional user fee revenues were 34.1 million lempiras.

6.2. From 1996 through 1999, institutional UF revenues grew at an average annual rate of 23 percent, and in 1999 were 70 percent above their 1996 level.

6.3. While growth in nominal terms was brisk, other indicators show the trend has not been positive:

a. As a percent of total central government-funded MOH expenditures are small and no trend is discernable over the past four years: From 1996 through 1999 the percentage oscillated between 1.8 and 2.2 percent.

b. In real terms (i.e., controlling for inflation), in 1999 institutional UF revenues were only 11 percent greater than in 1996.

c. Only national hospitals experienced growth in their real IUF revenues from 1996 through 1999. (See Graph ES-1.) In 1999, national hospitals were 42 percent above their 1996 real levels, whereas regional hospitals were 42 percent less, area hospitals were 45 percent and regions (the sum of the CESAMOs and CESARs) were 25 percent down from their 1996 levels.

6.4. With average prices relatively constant over most of this period, the growth in revenues has come from three different sources:

a. The growing levels of services provided by MOH facilities. Throughout all types of facilities the average number of ambulatory care visits provided in 1999 was nine percent greater than in 1996.

b. The growing number of MOH facilities with UFSs. Among the PHR survey sample of facilities, 38 percent began their UFS since 1996. Contributing to this trend is the fact that the number of MOH facilities grew by 17 percent from 1996 through 1999.

c. The newer UFSs have significantly higher average prices.

d. "Unbundling;" i.e., the growing practice of introducing separate charges for goods and services that used to be included in a single, all inclusive fee.

7. Total Community User Fee Revenues and Total UF Revenues Generated

7.1 Based on the weighted PHR sample, 1999 total community UFS revenues are estimated to have been 3.7 million lempiras.

7.2 Summing the estimated 1999 community and institutional UF revenues, total UF revenues are estimated at 37.8 million lempiras.

7.3 In 1999, community UF revenues constituted 11 percent of the total MOH user fee revenues.

8. Net Institutional User Fee Revenues in 1999

8.1 Administrative costs of the institutional user fee system in 1999 were 23 million lempiras.

8.2 The MOH paid 18.7 million lempiras of the administrative costs of the institutional UFS, 81 percent.

8.3 In 1999, the IUFSs generated 11.1 million lempiras in net revenues; i.e., for every lempira in revenue they brought in, they generated costs of 0.67 centavos. (Net revenues equal gross revenues minus costs: 34.1 million minus 23.0 million equals 11.1 million.)

8.4 Net institutional revenue generation varied significantly by type of facility:

a. National and regional hospitals: 19.3 million lempiras
b. Area hospitals: 3.9 million lempiras
c. CESAMOs and CESARs: negative 12.0 million lempiras

8.5 Only CESAMOs and especially CESARs had significant amounts of their costs paid by non-MOH sources. If only the MOH-financed portions of costs are included in the calculations, the CESAMOs and CESARs generated net revenues of negative 7.8 million lempiras.

8.6. It is important to note that many facility directors and administrators point out that user fees are of disproportionately great importance to them (relative to their other resources) because these revenues constitute most of the fungible resources at their disposable. For the most part, MOH resources are distributed in-kind, leaving relatively little room for the exercise of discretion and the actual purchase of the specific types and quantities of resources that a given facility might need. In contrast, user fees allow MOH staff to purchase exactly what they feel they need, (within the rules and regulations relating to their handling) as opposed to, at best, being able to choose from what is available from the MOH, and having to accept the uncertainties of when and if it will actually be delivered. This special appeal of user fee revenues results in many inefficiencies within the MOH system, as administrators are willing to use substantial amounts of existing MOH resources--viz., personnel time--to obtain a much smaller value of more liquid, fungible user fee revenues. While doing so may be economically irrational from a

system perspective, from the individual administrator's/director's perspective it may be entirely rational.

9. Community Participation and Municipal Government Support

9.1 A substantial proportion of surveyed facilities have some form of community participation. More specifically:

a. Sixty percent have a community health board,
b. Twenty-five percent have a patronato health committee, and
c. Twenty-six percent have a municipal government health committee.

9.2 Community health boards are becoming increasingly common. Fifty-five percent of them have been established in the last three years.

9.3 Eighty-six percent of the health board's members are elected to their positions.

9.4 Community health board elections are one-time events: they are held when the board is first established.

9.5 The RFRM provides no guidance about health board terms of office or composition. Once formed, they exist indefinitely and change composition/members only rarely and in an unplanned manner.

9.6 There are no mechanisms or regulations for structuring or coordinating the relationships between health facilities, health boards, patronato health committees or municipal health committees.

9.7 Twenty-seven percent of the surveyed facilities, and 35 percent of those that have at least one formal mechanism for community participation, have more than one, and often they are involved in the same activities. The absence of mechanisms or regulations for structuring or coordinating these relationships (especially when theire activities are overlapping), puts a health facility at risk of becoming entangled in conflicts which could prove debilitating and counterproductive to achieving the goals motivating the promotion of community participation.

9.8 Only 55 percent of the community health boards surveyed and 75 percent of patronato health committees surveyed had a health facility representative serving on them.

9.9 Not having representation in these different forms of community participation puts the health facilities at risk of having their user fee revenues and other resources managed without having the opportunity to have any input into the decision-making process. It is not clear that a health facility is necessary well served by these loosely structured, *ad hoc* arrangements.

9.10 The two major complaints expressed by the surveyed facilities' respondents about community user fee systems was the lack of transparency and the health board's administration of the system, both of which are due in large part to the facility not being allowed to participate in the decision-making processes of these community participation vehicles.

9.11 Where a health facility's user fee revenues are managed by a community health board without any input or representation by the health facility, we have a situation where there is ***not*** community ***participation*** in the management of these facilities, but rather community management of a portion of the facility's resources. This is not necessarily in the best interests of the health facility, and is not likely the type of situation that the RFRM meant to promote by encouraging the implementation of community user fee systems. Nonetheless, the absence of more specific guidelines in the RFRM allows for the development of this situation, which is fairly common.

9.12 Municipal governments are generally interested in, and provide support to their local health facility (facilities). Fifty-eight percent of the surveyed facilities reported they received some support from their municipal government.

9.13 A higher proportion of CESAMOs (74 percent) reported receiving municipal support than any other type of facility.

9.14 The average annual level of support provided by a municipal government was 15,000 lempiras per facility, the equivalent of roughly 85 percent of the facility's user fee revenues.

9.15 A substantial proportion of municipal support is probably financed by central government shared revenues. The Law of Municipalities mandated that the central government of Honduras annually allocate five percent of total central government tax revenues to municipal governments. According to Ministry of Finance personnel, however, only about 65 percent of municipalities are receiving the shared revenues they are due because the MEF regards the municipalities as incapable of adequately managing the monies. As the proportion of municipalities receiving shared revenues increases, it is likely that the value of municipal support for health facilities will increase.

10. The Views of Health Facility Interviewees: Problems and Proposed Solutions

10.1 All (100 percent) of the institutional UFS interviewees said the RFRM needs to be revised. The most commonly cited problem with the RFRM is the specific lempira-defined regulations.

10.2 All five of the RFRM exemptions are considered problems in operating the UFSs, apparently because they compromise cost recovery efforts and are administered in such a way that they compromise the transparency of the system and thus cast doubt on its fairness.

10.3 In response to an open-ended question about the problems of the UFS, the RFRM was again cited as the most important problem. The likelihood that RMRF restrictions were identified as the most important problem was inversely related to the level of the facility; among hospitals it is nearly universally so regarded, compared to 64 percent of CESAMOs and 24 percent of CESARs.

10.4 In response to an open-ended question about how to resolve the problems of the UFS, the most common response (74 percent) was to revise some aspect of, or the entire, RFRM.

10.5 Responding to the same question, regional office interviewees most commonly called for periodically increasing user fee levels to take into account inflation. More than half of the respondents also called for revising the RFRM.

10.5 In response to the open-ended question of what were the problems of the institutional UFSs, nearly three-quarters of community health board and municipal health committee interviewees said that they did not know.

10.6 The level of satisfaction among the health facility and community health board respondents with community systems is significantly greater than with institutional systems, 44 and 35 percent versus five and three percent, respectively.

10.7 Responses to the proposal for restructuring the institutional UFS and superceding regional office supervision with municipal government oversight was supported by six of the nine regional offices, but only about one-third of the health facility and health committee interviewees. The most common health facility response, however, was that it could not be done because this is not a function of the municipal government.

8.2 Recommendations for Reforming the RFRM to Improve the Performance of UFSs

The passage of the RFRM in 1990 was an important step in the development of the MOH. It has served the MOH well. It generated revenues for health facilities, while protecting the poor, and promoted decentralization. As this study has made clear, however, there are many shortcomings related to both the RFRM and to the implementation of MOH UFSs. After 10 years, these shortcomings are becoming increasingly restrictive and counterproductive to cost recovery efforts. The RFRM has now become an obstacle to improving the performance of the MOH in terms of its efficiency and effectiveness, and needs to be revised. The UFSs based on the *Regulation* are not effective cost recovery tools. They generate small amounts of revenues in absolute terms and as a percent of operating costs. The revenues they generate are decreasing in real terms in all types of MOH facilities, with the exception of the national hospitals. Furthermore, the systems are expensive to operate: their costs consume more than two-thirds of the gross revenues they produce. In addition, their prices are providing inappropriate signals to consumers to use the pyramidal referral system in an irrational manner, not as it was intended, and thus are a source of MOH inefficiency. Prices are in a general state of disarray: the prices of the same service provided in the same type of facility on average vary by a factor of five, or more. Moreover, relatively few facilities are in compliance with official MOH policy that mandates that six MOH priority services should be provided free-of-charge. Finally, there are indications that the situation is deteriorating. Continuing inflation means that adhering to the RMRF's nominal lempira-denominated regulations entails an ever-increasing administrative burden that is becoming increasingly costly, and encourages non-compliance with the law.

To ameliorate these problems the following recommendations are made:

1. To re-establish fee levels at their real 1990 levels, user fee levels should be increased five-fold.

2. Introduce fees that cascade by facility levels. For instance, set outpatient consultation fees for:
    i. CESARs at 5 lempiras
    ii. CESAMOs at 10 lempiras

iii. Hospitals at 15 lempiras, and consider cascading fees within hospital types, as well. For example, charge 25 lempiras for an outpatient visit at a national hospital, 20 lempiras at a regional hospital and 15 lempiras at an area hospital.

3. Review the contentious exemptions policy of the RFRM. Clarify specifically what categories of persons (including the RFRM's ambiguous "active, community personnel") are to be exempted from payment. Explicitly state whether MOH employees and/or their families are to be exonerated. Establish national level criteria / guidelines for identifying persons who are to be exempted from payment due to indigency. Application of the criteria should still be a local activity.

4. Revise RMRF purchasing restrictions, at minimum, to re-establish their real 1990 levels:
   i. Increase the rotating fund maximum from 2,500 to 12,000 lempiras.
   ii. Increase the maximum price that can be paid for a good or service before three price quotations are required from 100 to 500 lempiras.
   iii. Increase the maximum purchase value of a purchase of medicines that can be made without being required to obtain a quote from the MOH's Central Medicines Warehouse from 1,500 to 7,500 lempiras.
   iv. Increase the maximum value of a contract for non-personal services from 500 to 2,500 lempiras.

5. The MOH should modify the RMRF regulations that allow regional offices the right to share the user fee revenues of the facilities so as to start moving the Ministry toward a performance-based system. The regional offices' shared user fee revenues (10 percent from hospitals and 25 percent from health centers) should be used to establish a performance-based incentive scheme for facilities. Facilities that fulfill their performance goals (as established in an annual plan) should be awarded a "bonus" consisting of the revenues they would have otherwise had to share with the regional office. Those that do not fulfill their goals, would be subject to losing the shared revenue and the regional office would use it as it saw fit—as it currently does.

6. The San Felipe Regional Office's accounting and supervisory system for user fees is a model worthy of emulation. It should be used to establish uniform administrative standards for institutional user fee systems.

7. There is a need to clarify and raise awareness throughout the MOH and Honduran society of the RFRM, its rationale, its goals and the processes and procedures it establishes. The MOH needs to print and distribute to each facility a copy of the RFRM, and hold a series of regional office-sponsored meetings to discuss the Regulation and how user fee systems are supposed to function.

8. A series of public meetings should also be held and a publicity campaign undertaken for the same purpose. It is important to dispel doubts and concerns about the UFSs and the new fee levels. Empirical studies in some countries have found that misinformation about the magnitude of price changes discouraged a substantial proportion of persons from seeking care after a general increase in user fee levels (c.f., Bitran 1988).

9. There is a need to more precisely and comprehensively define what is a community user fee system. The MOH should develop more specific regulations governing the formation, composition and terms of office of health boards, as well as suggestive operating procedures and protocols.

10. Health boards that manage UF revenues should be required to have a voting representative of the local health facility director's choice on the board.

11. To promote community participation, accountability and transparency, consideration should be given to requiring the health board to make periodic public reports on user fee revenues and expenditures (perhaps at the *cabildos abiertos*—municipal governments are mandated by law to have at least five *cabildos abiertos* each year), and to make supporting documents readily available to the general public.

12. The MOH should provide guidance (suggestions) or regulations (legally enforced requirements) in terms of the types of structures, and operating procedures and domains for local entities interacting with a local MOH facility. The goal should be to promote community participation, while obviating conflict and protecting the integrity and operations of the local health care facility.

13. To draft these proposed changes—guidance, rules and/or regulations—a working group should be convoked with representatives from:
    i. the MOH's UPEG,
    ii. the MOH regional offices,
    iii. the Ministry of Governance and Justice, Municipal Technical Assistance Directorate,
    iv. the Honduran Association of Municipal Governments (AMHON),
    v. Representatives from a cross-section of the MOH's different types of facilities; e.g., 2 national hospitals, 2 regional hospitals, 2 area hospitals, 3 CESAMOs and 3 CESARs.

14. Determine if hospitals, or some subset of the hospitals, should have a different type of user fee system, or if they should be allowed to operate their systems independently. In either case, a uniform set of national guidelines should be developed to which all are required to adhere.

15. The Central Bank of Honduras' Department of Economic Studies, Division of Economic Aggregates, Economic Indicators Section should be tasked with using either the medical care price index component of the Consumer Price Index, or preferrably constructing an MOH-specific price index, that will be used to annually readjust MOH user fee levels to maintain them at the same constant, real value.[23]

[23] The Central Bank should be tasked with this responsibility, rather than the MOH, because this will better ensure its technical precision and will insulate the MOH from the political fall out of the annual increases. Each January the Central Bank should announce the next user fee levels and print the changes in the official government publication. Changes in fee levels should take into practical considerations, as well, so as not to increase the transactions cost of collecting the fees. For instance, if the inflation adjustment requires an increase to 3.32 lempiras, for example, the fee level should be increased to 3.25 or 3.30 so that making change does not become an unnecessarily time-consuming task.

8.3 The Case for a More Comprehensive Reassessment and Restructuring of the Current User Fee Policy Framework

The recommendations in the preceding section are predicated on the assumption that while current official policy will be modified, the general framework that the *RFRM* established 10 years ago will be retained. But should it? Should the Ministry retain the basic structure of the institutional UFS as set forth in the RFRM, and only change it as deemed necessary to address its shortcomings, or, should a fundamentally different approach be adopted? Due consideration should be given to fundamentally reformulating official MOH user fee policy. The RFRM is of another era. It is time to look forward to where Honduras has decided it wants to go; toward a more participatory, more decentralized form of government. How might the Ministry's user fee policy be made more effective, more participatory, more compatible with, and more supportive of the GOH's decentralization efforts?

It is useful to synthesize various strands of the discussion to this point, to provide a context for the ensuing discussion. The Ministry's user fee systems have stagnated with low and, in real terms, decreasing yields in all types of MOH facilities, with the exception of the national hospitals. These systems are not effective cost recovery mechanisms, and in the regions they are becoming increasingly less effective, in part because fee levels are so low and in the majority of facilities have remained unchanged since first being introduced a decade ago. The majority of facilities whose UFSs have never increased their fee levels hold their regional offices responsible for not allowing them to increase. Many of these systems have been rendered inert by the lack of understanding by several of the regional offices of what their role is in setting prices. This misunderstanding and ignorance has been exacerbated by a lack of leadership on the part of these same and other regional offices to exercise the authority they have been delegated over these systems. Further compounding the situation has been the absence of oversight or regular substantive reviews of the structure of operations of the UFSs by central office officials. The RFRM does not identify any specific MOH central office as overseer of, or advisee to, the regional offices in their shepherding of the UFSs. The absence of a future-oriented vision in the RFRM (perhaps best exemplified by the nominal lempira-denominated regulations with no identified procedures or suggestions for periodically updating these amounts), coupled with the no central office role, dissipated attention to, and technical capability in support of, user fee systems.

In sum, ill-considered and inadequately specified plan for decentralization has rendered these systems effete and obscure. To the extent to which there has been change in these systems, the dynamics have largely come from outside of it. Total nominal revenues are increasing due to increasing numbers of consultations, increasing numbers of UFSs as the number of facilities continues to grow, increasing numbers of community systems and perhaps to increasing evasion and non-compliance with the RFRM. This is not a healthy situation. The RFRM, the legal framework of UFSs, is in need of fundamental reform. The regional office-based scheme no longer serves the Ministry well. While it can be much improved with some reforms, is that as good as can be expected? Or can that system be modified in such a manner that it, at once, becomes more effective and better supports other GOH goals; viz., decentralization?

The GOH has embarked on a far-ranging program for modernizing the public sector. One of the key pillars of this program consists of decentralization. It should be recognized that the Ministry of Health was far ahead of its time when it decentralized control of the user fee systems to the regional offices 10 years ago, with the passage of the RFRM. The Ministry, however, has made virtually no progress in decentralization since then, despite the fact that the GOH has made substantial reforms toward that end. In large part this is because the current configuration of the MOH has made it difficult to know where to start. The current structure of the Ministry does not coincide with political

boundaries of the country. The regional offices, for example, combine various departments and sometimes cut across departmental boundaries to include only portions of departments. This has raised a contentious question: To which level should the Ministry be decentralized? Initial proposals called for decentralizing to the departmental level, where there is currently only a modicum of government, raising the issue of whether it was necessary or desirable to first create some type of deconcentrated MOH structure at that level before decentralization could proceed. If that is to be the course of action, what then becomes of the regional offices? Others have argued that Honduras is small enough that decentralizing to the department and dividing the MOH into 18 administrative units is unduly complex, costly and unncessary. This debate has not been resolved and now constitutes an impasse to further decentralization of the Ministry of Health.

The GOH's modernization plan calls for transferring much of what the central government does down to the municipality. To be in-step with this plan, and to anticipate changes that otherwise will likely eventually be foisted on the MOH in order to make it consistent with the rest of the government, the Ministry would have to transfer responsibility and authority to municipal governments. This would constitute a different type of decentralization, one that is referred to as devolution, which is distinguished by the transfer of power to a different public entity. Here too, the Ministry of Health is a pioneer. It took its first step in this process of devolution 10 years ago. That step consisted of the RFRM allowing community health boards to take over supervision of community UFSs. This study has found that there is significantly greater satisfaction with community systems compared to institutional systems among both the health facility and community health board respondents. The basic approach of the community user fee systems is one that is popular, consistent with, and supportive of the GOH's public sector modernization program. It could be adopted and adapted to devolve oversight of the UFSs to the municipal governments, rather than to community health boards.

It would be advisable to recognize that there are problems with these systems which were identified in the survey, and which should be addressed before adopting this approach as a means for devolving oversight of the UFSs to the municipal governments. Most of the problems have a common root, and stem from the nature of this type of decentralization, devolution. In this case, devolution has meant that non-health people have been given authority over the health sector. The health personnel not being given representation to communicate the health facility's needs and not being able to participate in the decision-making process determining what is to be done with the user fee revenues generated by the health facility, has left many health staff working in community systems feeling vulnerable, "robbed" of their facility's income and powerless. While the proposed reforms are intended to ameliorate this situation, the community system will continue to be headed by the community health board, which is likely to eventually prove problematic (as explained below). At the other extreme, are the community systems that independently manage their own funds either because the community health board no longer functions or because it is not interested in managing these monies. Both of these situations reflect what this study and others (c.f., Fiedler and Godoy, 1999 and Corrales, et al., 1998) have found: that maintaining adequate interest, vigor and transparency in activities in which there is community participation with authority resting in a largely unstructured, *ad hoc* entity--such as a community health board--has been and, in all likelihood will always be, problematic. While the proposed reforms seek to obviate these potential shortcomings, the sustainability of quantitatively and qualitatively meaningful community participation could be better ensured if a more permanent, more institutionalized system were developed. Properly restructured, devolution to the municipal level and, more specifically, to a municipal health committee, offers an attractive alternative with greater, more enduring promise.

It should be acknowledged, however, that devolving oversight of the user fee systems to the municipal level probably entails greater risks for the MOH and for health facilities than simple

deconcentration. Again, this is due to the distinct nature of devolution vis-à-vis deconcentration. The municipal governments, to date, are not knowledgeable about the health sector or the functioning of health facilities or their user fee systems, and, in fact, have not even been much involved, until very recently, in the health sector. Devolution of oversight of the user fee systems to the municipal health committee, therefore, runs the same risks as devolution to the community health board; viz., that non-health people who are put in a position of authority over the health sector, may compromise the health sector for other goals these persons might have.

In response to this scenario, two observations are in order. First, the knowledge of municipal authorities, in general, about the health is increasing rapidly, and is likely to continue to increase for two reasons:

1. As has been demonstrated in this study, at the local level Hondurans regard health as an important priority, and, as politicians, municipal authorities are likely to be aware of and responsive to this keen interest.

2. Municipal governments have been financially empowered by the new Law of Municipalities-established revenue sharing scheme, and they are putting their money where their priorities are; i.e., into their local health facility.

The second observation is that the terms by which the supervision of the user fee systems are devolved to the municipal health committee is subject to negotiation. The MOH should be prepared to play a prominent role in structuring this relationship so as to better ensure that health and the interests of public health officials are well served. The Ministry can achieve this goal, by adopting many of the same reforms recommended earlier for the community user fee systems and applying them to the proposed municipal health committee systems, as well. These reforms seek to strengthen the health facility's position within the devolved system, thereby making this a more attractive option for MOH facility staff, while providing a more structured set of regulations that make the system more participatory and more transparent, thereby enhancing its appeal to the community.

It is imperative that these reforms also be structured in such a manner as to ensure that the Ministry of Health retains the ability to effectively implement a national health policy. In other words, there is a need to strike a balance between devolving authority and responsibility to the municipality, while retaining adequate authority at the central level so as to protect the integrity of the health sector and retain the Ministry's ability to establish national health priorities and lead the health sector in pursuing those priorities.

Although municipal governments are already actively involved in supporting MOH facilities, the majority of facility representatives interviewed in this study expressed reservations and generally did not support the idea of having the municipal government take the place of the regional office as the supervisor of local user fee systems. It must be recognized, however, that their expressed preferences are conditioned by their experiences, which in many cases are shaped by the ill-defined community UFSs and their community health boards, and/or by the interactions between the municipal government and the facility, which to date have been unstructured.

Another way in which the facility-municipal government relationship could be structured so as to obviate some of the specific concerns raised by the facility personnel would be to prohibit the expenditures of a facility's user fee revenues for anything other than the facility's needs. This prohibition could also be complemented with the stipulation that only the municipal health committee has the authority to determine how those funds are spent. The role of the municipal government

would be limited to providing oversight of the revenues and expenditures, and ensuring the integrity of the monies.

Furthermore, the GOH could make it optional for a facility to enter into this type of relationship, much like the RFRM did for the development of community health boards to govern community UFSs. Making the relationship between a municipal government and a health facility voluntary, together with the recommended reforms to better ensure the representation of, or independence of, the health facility would further heighten awareness that the relationship is more of a partnership, while promoting transparency in the management of the monies. Consideration might also be given to establishing a phasing-in period during which this type of relationship could be entered into voluntarily, with a schedule, or perhaps only the hope that later it might become universal and mandatory. The phase-in could include annual assessments of how well the system is working, with the introduction of subsequent modifications to address identified shortcomings.

The proposed approach serves several ends simultaneously, some of which have already been mentioned but merit reiteration at this juncture. This approach would constitute the first step in the long talked about, but long delayed beginning of the decentralization of the Ministry of Health. Second, it overcomes the impasse regarding to what level of government the MOH is to be decentralized. Third, it is consistent with the GOH's decentralization plans that are focused on the municipality. Fourth, it constitutes what may be regarded as the first step in eventually devolving the Honduras public health care delivery system (at least the health centers) to municipal governments. This is consistent with the Ministry's ultimate, long term goal of getting out of the business of being a direct provider of health care, while increasingly focusing its activities exclusively on financing, regulation and being the rector of the health sector.

Concomitantly, the approach provides a means by which to help move the entire country further along the road of decentralization. The management of user fees can provide a type of training ground to municipalities that have not yet had the opportunity to develop administrative capacity. Allowing them to oversee the administration of user fee systems can be a means whereby they break what in some instances has become a vicious circle that could persist for a long time and delay or derail Honduras' efforts to decentralize. The vicious circle that currently exists in some municipalities is that they are poor, have traditionally not had a local (municipal) governmental structure, have no resources to administer, have no administrative experience and thus do not have administrative capacity. This situation becomes self-perpetuating—i.e., the circle is closed—because these municipalities are not able to acquire administrative capacity because they have no resources manage. These are the municipalities—roughly a quarter of the total number of 233 in Honduras—that the Ministry of Economy and Finance (MEF) has determined it will not allocate their share of the Law of Municipalities' designated five percent of central government tax revenues, because these municipalities do not have what MEF regards as adequate administrative capacity to ensure that the funds will be used properly. These municipalities are effectively locked out of decentralization, at least for the time being. Giving them the opportunity to administer user fee revenues could help to break this vicious circle. It is not the solution to this problem, in and of itself, but it can help.

8.4 Conclusion

The effectiveness of the Ministry of Health's user fee systems has been slowly crumbling under the weight of the increasingly restrictive and outmoded RFRM. There is an urgent and growing need to reform the RFRM so as to enable the restructuring and reinvigoration of these systems. Fee levels need to be increased, and the systems need to be made more formal, with more explicitly established operating goals, rules and procedures so that they are more effective in recovering costs and

encouraging community participation in a manner that obviates conflict, promotes transparency, and yet protects the resources, operations and integrity of the local health facility's operations and the operations of the entire MOH. This study has made a series of what should be regarded as minimum recommendations for revising the RFRM. It has called for the formation of a working group (composed of representatives of specifically identified agencies) to oversee this process and to consider a more ambitious agenda, which aims to integrate the Ministry of Health more fully into the Government of Honduras' general decentralization initiative by devolving oversight of the UFS to municipal governments, and does so in a manner that is highly flexible and serves the present and future needs of both the Ministry of Health and Honduran society.

Annex A: The Sampling Methodology

Based on the findings of the user fee system inventory it was decided that the sampling methodology should take into account the marked variations found by region, type of facility and type of user fee system. It was determined, however, that stratifying the sample by all of these variables would result in too many strata. With nine regions, eight levels and four types of user fee systems, there would be 288 cells (288 = 9 x 8 x 4). Accordingly, the approach was simplified by combining some of the facility levels. The Maternal-Infant Clinics and the CLIPERs categories were combined with the CESAMOs and the 11 Dental Student Centers were dropped from the analysis. Prompted by recognition that the 29 hospitals account for 75 percent of the IS user fee revenues, it was decided that all of the hospitals would be included in the sample. These simplifications left a maximum of 72 cells (nine regions multiplied by two levels--CESAMOs and CESARs--multiplied by four types of user fee systems). With no information available on Region 8 and with 15 other cells empty, there were 49 cells into which the 862 MOH facilities for which there were data and that were reported to have some type of user fee system were categorized. The resulting "universe" of 862 facilities is presented in Table A-1. The 49 cells consist of 26 CESAMO and 23 CESAR cells.

Available time and resources were the key determinants of the sample size. It was determined that the sample would consist of at least a 15 percent sample of each of the 26 CESAMO cells and each of the 23 CESAR cells (identified in Table A-1). Given the perceived greater relative financial significance of the CESAMOs' UFSs and the complete lack of systematic information about community user fee systems, it was decided that CESAMOs with CSs would be over-sampled to provide a more precise and comprehensive picture of these systems. Again, driven primarily by time and resource constraints, it was judged feasible to survey the 10 additional facilities that a minimum sample size of 30 percent of each of these cells would entail (compared to a 15 percent sample) within the two month time period allotted for the fieldwork. Table A-1 presents the resulting sampling frame for the non-hospital facilities.

Initially it was planned that a random sample would be drawn from each of the cells. Before that was done, however, an analysis of a number of other characteristics which were hypothesized to be causally related to the motivation for having a user fee system and to the type of administrative system and the level of user fee revenues generated was conducted in order to determine if these variables should also be taken into consideration in identifying the sample. The variables investigated were:

1. the number of consultations provided by the facility in 1998,
2. a measure of the average per capita household income in the municipality (*municipio*),
3. an index of the health status of the population of the municipality.
4. whether or not the facility had an active local Health Committee or Health Board,
5. whether or not the facility received support from its municipal government,
6. whether or not the facility had a laboratory, and
7. whether or not it offered dental services.

The discussion now turns to a description of why these variables were regarded as potentially important to take into account, what additional data analysis found and the final determination of which of these additional considerations was judged pertinent to incorporate into the sampling procedure.

Table A-1
The Sample of Non-Hospital Facilities
Fifteen Percent of Each Strata*

A. The Universe of Facilities

		C E S A M O s **					C E S A R s					Total of CESAMOs and CESARs
	Region	Institutional System (IS)	Community System (CS)	IS & CS, Separate	Mixed	Total	Institutional System (IS)	Community System (CS)	IS & CS, Separate	Mixed	Total	
0	Metropolitana	19				19	3				3	22
1	San Felipe	20	3	2	13	38	1	86	3		90	128
2	Comayagua	17	2	1	2	22	16	67	4	13	100	122
3	San Pedro Sula	13		13	19	45	18	36		10	64	109
4	Choluteca	25	6		1	32	13	131		4	148	180
5	Copan	31		2	1	34	30		3		33	67
6	La Ceiba	17	3	1	4	25	15	65	2	4	86	111
7	Juticalpa	9	1	10	3	20	18	83		2	103	123
8	Puerto Lempira					0					0	0
		151	15	29	43	235	114	468	12	33	627	862

B. The Planned Sample of Facilities

		C E S A M O s **					C E S A R s					Total of CESAMOs and CESARs in the Sample
	Region	Institutional System (IS)	Community System (CS)	IS & CS, Separate	Mixed	Total	Institutional System (IS)	Community System (CS)	IS & CS, Separate	Mixed	Total	
0	Metropolitana	3				3	1				1	4
1	San Felipe	3	1	1	4	9	1	13	1		15	24
2	Comayagua	3	1	1	1	6	3	11	1	2	17	23
3	San Pedro Sula	2		4	6	12	3	6		2	11	23
4	Choluteca	4	2		1	7	2	20		1	23	30
5	Copan	5		1	1	7	5		1		6	13
6	La Ceiba	3	1	1	2	7	3	10	1	1	15	22
7	Juticalpa	2	1	3	1	7	3	13		1	17	24
8	Puerto Lempira					0					0	0
		25	6	11	16	58	21	73	4	7	105	163

It is hypothesized, other things being equal, that those facilities that provide more consultations will be more likely to have a UFS and that they will generate larger incomes from those systems. It is further hypothesized that the characteristics of a facility's catchment area population will affect the probability of having a UFS and the level of reveneues that the system generates. Catchment populations with higher incomes are likely to be more willing and able to pay something for the health services they receive, and are likely to have fewer persons who are exonerated from paying by virtue of their indigency. Other things being equal, catchment populations with lower health status are more likely to seek care and to seek more care per person. Other things being equal, facilities with catchment area populations with low health status, therefore, are more likely to have higher user fee revenues.

Evidence from the field visits Fiedler and Sandoval made during Fiedler's previous trip suggested that facilities with laboratories and dental services were likely to charge for these ancillary services and that these services generated considerable revenues. These observations led them to hypothesize that facilities with labs and dentistry services had systematically different user fee administrative systems and revenues. Acccordingly, they included in the UPEG survey of MOH facility characteristics questions about whether or not a facility had a laboratory or dental services.

The UPEG survey found that CESARs do not provide lab or dental services. These criteria, therefore, were pertinent only for categorizing CESAMOs. According to the UPEG survey, sixty percent of CESAMOs do not have either dental services or a lab, and 25 percent have both. It was also found that only 23 percent of CESAMOs with dental services did not have a laboratory, and that only 26 percent of those with a lab did not provide dental services. In short, among the facilities with either a lab or dental services, most had both. Thus, in order to simplify the approach, it was decided to use just one of these two variables to classify CESAMOs.

From field visits and discussions with regional and central office personnel it appears that there are many instances where community health committees have been established. However, after an initial high level of activity within, and oversight of, the health centers and their user fee systems, many health committees have slowly evolved into moribund institutions. In some instances, health centers now apparently manage their own CSs, largely or entirely, on their own, with little or no oversight or community participation. In order to better understand the importance and patterns of community participation, the UPEG survey included identifying whether or not the facility had an active health committee or municipal support.

The survey revealed that 55 percent of CESARs have neither a health committee nor municipal support. In CESARs, health committees are the most common of these two types of community participation. Thirty-eight percent of CESARs have a Health Committee, compared to only 24 percent that have municipal support. Of those with the support of the municipality, 68 percent reported they also had the support of a junta. For CESARs, the health committee variable alone accounts for most of the variability in these two types of community participation. Accordingly, it was decided that of the two community participation variables, only the health committee variable would be included in developing the CESAR sampling procedure.

The CESAMOs, again, were found to be different from the CESARs. From the UPEG survey it was learned that twice as many CESAMOs have municipal support as have an active health committee. Of those with municipal support, 30 percent also have an active committee. Sixty percent of CESAMOs with an active committee also enjoy municipal support. Thus for CESAMOs, most of the variation in community participation is captured by the municipal support variable. Again, in the

interest of simplifying the approach, it was decided that of the two community participation variables, only the municipal support one would be considered in developing the CESAMO sampling procedure.

For CESAMOs, this preliminary analysis and the simplifications they prompted resulted in there being five additional variables:

1. the total number of 1998 consultations,
2. the existence of a laboratory,
3. the existence of municipal support,
4. a health status index, and
5. the level of per capita income,

that were regarded as important to take into account in developing the sample.

For CESARs, the analysis concluded that there were four additional variables:

1. the total number of 1998 consultations,
2. the existence of an active health committee,
3. a health status index, and
4. the level of per capita income,

that were to judged to be essential to take into account in devising the sample. For both CESARs and CESAMOs, however, rather than introducing additional strata, an alternative approach was adopted.

In order to identify the specific facilities that would be sampled, a statistical procedure, cluster analysis, was applied to each of the 49 cells. For each cell, all of the facilities in the cell were assigned to relatively homogenous groupings based on additional characteristics that are hypothesized to result in systematic variations in the structure and operations of UFSs. For each facility that is to be sampled in a particular cell, one group or cluster is developed. For example, a cell from which five facilities are to be sampled (as shown in Table A-1), will have five groups or clusters. Cluster analysis was used to form the groups and to assign all of the facilities (within the cell in which it is being applied) to one group, simultaneously taking into account the value of all of the clustering variables (five for CESAMOs, four for CESARs).[24]

Rather than leaving it to chance (as would be the case with a random sample), it was decided that it would be preferable to select the facility that is most representative of each cell or grouping of facilities. The cluster analysis was used to create a new variable indicating the Euclidean distance between each case and its classification (group) center. In each cell, the facility that was closest to the cluster's center was identified and selected to be in the sample and surveyed. The facility that is closest to the cluster's center is the one that is most representative of each group of facilities (i.e., of

[24] Facilities are grouped together based on the minimization of the Euclidean distance. The Euclidean distance measures the distance between two cases as the sum of the differences between the values of the clustering variables. The K-means Cluster Analysis algorithm of the Statistical Package for the Social Sciences (SPSS) was used. All of the variables used in the analysis were standardized before performing the analysis. In all cases, convergence was achieved with less than five iterations.

Table A-2
The Sample of Non-Hospital Facilities:
Planned and Actual

A. Planned

Region	CESAMOs				CESARs				Total of CESAMOs and CESARs
	Institutional System (IS)	Community System (CS)	Mixed System (IS & CS)	Total	Institutional System (IS)	Community System (CS)	Mixed System (IS & CS)	Total	
0 Metropolitana	3			3	1			1	4
1 San Felipe	3	1	5	9	1	13	1	15	24
2 Comayagua	3	1	2	6	3	11	3	17	23
3 San Pedro Sula	2		10	12	3	6	2	11	23
4 Choluteca	4	2	1	7	2	20	1	23	30
5 Copan	5		2	7	5		1	6	13
6 La Ceiba	3	1	3	7	3	10	2	15	22
7 Juticalpa	2	1	4	7	3	13	1	17	24
8 Puerto Lempira				0				0	0
	25	6	27	58	21	73	11	105	163

B. Facilities Actually Surveyed

Region	CESAMOs*				CESARs				Total of CESAMOs and CESARs in the Sample
	Institutional System (IS)	Community System (CS)	Mixed System (IS & CS)	Total	Institutional System (IS)	Community System (CS)	Mixed System (IS & CS)	Total	
0 Metropolitana	4			4	1			1	5
1 San Felipe	2	1	6	9		14	1	15	24
2 Comayagua	8	1		9	2	11		13	22
3 San Pedro Sula	13		1	14		7	1	8	22
4 Choluteca	8	1		9	17	1	2	20	29
5 Copan	13			13		2		2	15
6 La Ceiba	8		1	9		12		12	21
7 Juticalpa		2	2	4		14	1	15	19
8 Puerto Lempira				0					0
	56	5	10	71	20	61	5	86	157

the facilities within the particular cell of interest from Table A-2), as measured by the minimization of the Euclidean distance of the differences in the clustering variables. This technique was used to identify the 58 CESAMOs and the 105 CESARs that were in the sample.

The Facilities in the Sample versus the Facilities that were Surveyed

The team of interviewers and the MOH study team surveyed 186 facilities, 9 regional offices and 82 health committees and 53 mayors' office (alcaldes). The facilities that were surveyed did not completely coincide with the originally identified sample of facilities due to (1) health facility personnel not being available or (2) because the facility being temporarily closed because staff were ill, or on maternity leave or vacation. This was primarily a problem with CESARs, where generally there is only a single staffperson.

Some of the CESARs and a fewer number of the CESAMOs the type of user fee system the PHR interviewers identified differed from that which regional office staff had reported in the user fee inventory. The most common type of apparent misclassification by regional office staff was that they perceived what the health facility personnel identified as institutional systems, to be mixed systems. This accounts for the discrepancy in the number of mixed systems that were planned to be surveyed, and the substantially smaller number (less than half) that actually were interviewed. Table A-2 presents the planned sample and the actual sample of facilities that were surveyed.

Since the composition and size of the planned and actual sample of facilities varied, it was necessary to recalculate the expansion factors with which to develop nation-wide estimates from the sample. This was particularly important for developing the first-ever, national estimates of the community user fee system revenues.

Assessing the weighting scheme for obtaining national level estimates

An assessment of the final sample weighting scheme was performed. It consisted of comparing the weighted sample-based consultation estimates to official MOH data (the Statistics Department's AT2 files). As is shown in Table A-3, the weighted sample-based estimate of total consultations varied from the official MOH total by 0.03 percent.

Given the importance in this study of those services that the MOH mandates (in the RMRF) to be provided free of institutional user fee charges, more specific comparisons were also made of: prenatal care, growth and development, family planning, tuberculosis and sexually transmitted infections (STIs).[25] The coincidence between the weighted sample-based estimates and official data for these specific types of visits was less than that of the total consultations, as may be seen in the Table, but were an acceptable approximation for purposes of this study.

[25] The tuberculosis and STI visit analyses were developed from the MOH's Infectious Disease monthly reporting system. The raw data files were obtained from the MOH's Statistics Department and analyzed.

Table A-3
Evaluating the Accuracy of the Sample Weighting Scheme
Comparing Weighted Sample-Based Consultation Estimates with MOH Official Data*

	Prenatal Care	Growth & Development	Family Planning	Transmissible Diseases	All Consultations
MOH 1999 Totals*	480,785	1,619,794	178,083	7,431	6,416,696
Weighted Sample Totals	420,405	1,450,561	157,551	5,665	5,683,168
Adjusted Weighted Sample Totals: Adds in AT2 totals for CESARs without user fee systems excluded from the sampling frame and sample.	491,389	1,704,777	181,425	6,400	6,414,519
Adjusted Weighted Sample as a Percent of MOH Totals	102.2%	105.2%	101.9%	86.1%	100.0%

Annex B: Questionnaire

SECRETARIA DE SALUD
UNIDAD DE PLANEAMIENTO Y EVALUACION DE DE LA GESTION (UPEG)
Proyecto PHR/USAID

DIAGNOSTICO DE LOS SISTEMAS DE FONDOS RECUPERADOS
Cuestionario para las UPSs

Hola buenos días/ tardes), mi nombre es_____. Nosotros estamos realizando un estudio para la Secretaría de Salud, con la participación de las Alcaldías y los Comité de Salud de la comunidad. Me gustaría hacerle algunas preguntas acerca de los sistemas de recuperación de fondos y de la gestión administrativa y financiera que de ellos se realiza a nivel local. Nosotros agradecemos enormemente su contribución y apreciamos el tiempo que usted va a tomar para responder a nuestras preguntas.

Sección I. Aspectos Generales.

Me gustaría comenzar haciéndoles unas preguntas de carácter general y que pretenden ubicar a la UPS dentro del régimen político administrativo del país, las regiones de salud y su caracterización por niveles de atención.

A1. Fecha:___/___/_____ Formulario # 1_____

A2. Ubicación:

(a) Departamento _____	(d) Región _____
(b) Municipio _____	(e) Area _____
(c) Comunidad _____	(f) UPS _____

A3. Persona entrevistada: _____Cargo: _____

a. Número telefónico: (1) _____(2) No tiene _____

A4. Características de la UPS: [Encierre en un circulo, sólo uno]

1. Hospital Nacional
2. Hospital Regional
3. Hospital de Area
4. CESAMO
5. CESAR
6. Clínica Materno Infantil
9. Centros Escolares Odontológicos

Nota para el entrevistador: el nivel 8 es UPS privada

7. Clínica de Emergencia

Sección II. Cuantificación de personal médico en Consulta Externa.

Ahora me gustaría hacerle unas pocas preguntas sobre el número de personal médico asignado a la UPS y que realiza actividades en el servicio de Consulta Externa.

A.4.a. Número de médicos en consulta externa_____ (Incluye médicos permanentes especialistas y generales, por contrato, y en servicio social)

A.4.b. Horas médico trabajadas en consulta externa (promedio)_____meses
A.4.c. Número de enfermeras profesionales en consulta externa_____

A.4.d. Número de auxiliares de enfermería en consulta externa_____

Sección III. El Sistema y Manual de Fondos Recuperados.

Ahora quisiera conocer su opinión sobre el sistema y manual de fondos recuperados que utiliza la Secretaria de Salud.

1. La UPS tiene un sistema de recuperación de fondos? _____Si _____ No

2. Si la respuesta es "Sí": ¿Qué tipo de sistema tiene la UPS ?

   2a. Institucional (que usa los talonarios de la controlaría) ____ Si _____ No

   2b. Comunitario ____ Si _____ No

   2c. Mixto (los dos integrados) ____ Si _____ No

3a. Si #2a es "Sí": ¿Cuándo empezó el sistema institucional? _____ Fecha

3b. Si #2b es "Sí":¿Cuándo empezó el sistema comunitario?_____ Fecha

3c. Si #2c es "Sí": ¿Cuándo empezó el sistema mixto?_____Fecha

4a. Si la respuesta #2a es "Sí": Hay un manual que explique el manejo del sistema institucional? _____ Si _____ No

4.a.a Pudiera enseñármelo? Si, tienen una copia ___ No, no tienen una copia ___

4b. Si la respuesta #2b es "Sí": Hay un manual que explique el manejo del sistema comunitario? _____ Si _____No

4.b.a. Pudiera enseñármelo? Si, tienen una copia ___ No, no tienen una copia ___

4c. Si la respuesta # 2c es "Sí": Hay un manual que explique el manejo del sistema mixto?

4c.a. Pudiera enseñarmelo? Si, tienen una copia _____ No, no tienen una copia ___

5. Conoce el Reglamento y Manual del Uso de Fondos Recuperados? ____ Si ____ No

5.a. Pudiera enseñármelo? Si, tienen una copia _____ De que año es? _____No, no tienen una copia _____

Sección IV. Cuotas por Tipo de Servicios.

Usted nos puede ayudar a conocer las cuotas que cobran por los servicios de salud en ambos sistemas y los cambios habidos.

6.Cuáles son las cuotas que se cobran por los servicios siguientes: [Le voy a leer las siguientes opciones].

Servicio	Cobro-Sist.Institucional	Cobro-Sist.Comunitario
6a La consulta: General	Lempiras	Lempiras
6b. La consulta: Especializada	Lempiras	Lempiras
6c. Laboratorio: Exam.Rutina	Lempiras	Lempiras
6d. Lab: VDRL	Lempiras	Lempiras
6e. Lab: Gravindex	Lempiras	Lempiras
6f. Lab: Químico (sanguíneo)	Lempiras	Lempiras
6g. Lab: Otros	Lempiras	Lempiras
6h. Odontología-extracción	Lempiras	Lempiras
6i. Odontología-Limpieza	Lempiras	Lempiras
6j. Odnt:Obturación, Provisional	Lempiras	Lempiras
6k. Odnt:Obturación,Amalgama	Lempiras	Lempiras
6l. Odnt:Obturación,Composite	Lempiras	Lempiras
6m.Tarjetas (carnet) de salud	Lempiras	Lempiras
6n. Rayos-x: Placas tórax	Lempiras	Lempiras
6ñ. Rayos-x: Placas simple (Especifique)	Lempiras	Lempiras

Notas para el entrevistador. Un ejemplo de placa simple es Rayos-X del cráneo. Un ejemplo de placa especial es el

6o. Rayos-x: Placas especiales (Especifique)	Lempiras	Lempiras
6p. Rayos-x: Placas especiales (Especifique)	Lempiras	Lempiras
6q. Otro (Especifique)	Lempiras	Lempiras
6r. Otro (Especifique)	Lempiras	Lempiras
6s. Otro (Especifique)	Lempiras	Lempiras
6t. Otro (Especifique)	Lempiras	Lempiras
6u. Otro (Especifique)	Lempiras	Lempiras
6v. Otro (Especifique)	Lempiras	Lempiras
6w. Otro (Especifique)	Lempiras	Lempiras
6x. Otro (Especifique)	Lempiras	Lempiras

7. Alguna vez la UPS ha cambiado la cuota de cobro por servicio? ____Sí ____No

   Si la respuesta es "Sí": 7a. Cuándo fue la última vez? _____(Fecha)

   Si la respuesta es "No": 7b. Por qué no lo hace: [Le voy a leer algunas opciones].

   7b1. El Reglamento no da la autoridad para hacerlo _____
   7b2. La Oficina Regional no da la autoridad para hacerlo _____
   7b3. Los gremios no permiten hacerlo _____
   7b4. Otro (Especifique)

   _____
   _____
   _____

_____

7b.5. Otro (Especifique) _____
_____
_____
_____
_____

Sección V. Los Servicios de Salud Gratuitos.

Ahora desearía que usted respondiera a las preguntas que buscan identificar cuales son servicios gratuitos en cada sistema de salud, quiénes no pagan y quién toma la decisión.

8. Hay algunos servicios que son siempre gratuitos para todos los usuarios?_____ "Sí" _____"No". Si la respuesta es "No" pase a la pregunta # 10

9. Si la respuesta # 8 es " Sí": Cuales son los servicios gratuitos?. [Le voy a leer las siguientes opciones]

Tipo de Servicio	**Gratuito en el Sistema Institucional**	**Gratuito en el Sistema Comunitario**
9a. Consultas prenatales		
9b. Crecimiento y Desarrollo		
9c. Inmunizaciones/Vacunas		
9d. Planificación Familiar		
9e. Enferma. de Trans. Sexual		
9f. Tuberculosis		
9g. Otros (Especifique)		
9h. Otros (Especifique)		
9i. Otros (Especifique)		
9j. Otros (Especifique)		

9. En los otros servicios que presta la UPS, (que no estuvieron mencionados en #9), todos los pacientes tienen que pagar la cuota normal?
   10a. En el sistema institucional: ____ Sí ____ No
   10b. En el sistema comunitario: ____ Sí ____ No

10. Si la respuesta #10a es "No": Cuáles tienen que pagar o pagan solo una parte del cobro normal en el sistema **institucional**?

Grupos de Personas	No Pagan Nada (Sist. Instit'l)	Pagan solo una Parte (Cuanto paga en promedio)
11a. Los Pobres (que no pueden pagar)		
11b. Empleados de la Sec. De Salud		
11c. Miembros de la Familia de Empleados de la Secretaría de Salud		
11d. Colaboradores Voluntarios		
11e. Monitoras de Nutrición		
11f. Voluntarios / Guardianes de Salud		
11g. Parteras		
11h. Miembros del Comité o de la Junta de Salud		
11i. Otros (Especifique quien)		
11j. Otros (Especifique quien)		
11k. Otros (Especifique quien)		

11. Si la respuesta a #10b es "No": ¿Cuáles no tienen que pagar o pagan solo una parte del cobro normal en el sistema **comunitario**?

Grupos de Personas	No Pagan Nada (Sist. Instit'l)	Pagan solo una Parte (Cuanto paga en promedio)
12a. Los Pobres (que no pueden pagar)		
12b. Empleados de la Sec. de Salud		
12c. Miembros de la Familia de Empleados de la Secretaría de Salud		
12d. Colaboradores Voluntarios		
12e. Monitoras de Nutrición		
12f. Voluntarios / Guardianes de Salud		
12g. Parteras		
12h. Miembros del Comité o de la Junta de Salud		
12i. Otros (Especifique quien)		
12j.Otros (Especifique quien)		
12k. Otros (Especifique quien)		

12. En el sistema **institucional**: Si los pobres no tienen que pagar, quién determina quiénes son los pobres?

(En la primera columna indique "X" si la persona participa en la decisión. En la segunda columna, indique todos los que participan en la decisión: Si hay más de una persona, indique con "1" lo más frecuente, con "2" el segundo más frecuente, etc.)

13a. El Director _____ _____
13b. El Administrador _____ _____
13c. Receptor de Fondos _____ _____
13d. Una auxiliar de enfermería _____ _____
13e. Una enfermera profesional _____ _____
13f. Un médico _____ _____
13g. Un trabajador social _____ _____
13h. Encargado de farmacia _____ _____
13i. Otro (Especifique quien) _____ _____
_____

13. En el sistema comunitario: Si los pobres no tienen que pagar, quién determina quienes son los pobres?

(En la primera columna indique "X" si la persona participa en la decisión. En la segunda columna, indique todos los que participan en la decisión: Si hay más de una persona, indique con "1" lo más frecuente, con "2" el segundo más frecuente, etc.)

14a El Director _____ _____
14b. Comité de Salud _____ _____
14c. Una auxiliar de la enfermería _____ _____
14d. Una enfermera profesional _____ _____
14e. Un médico _____ _____
14f. Un trabajador social _____ _____
14g. Otro (Especifique quien) _____ _____
_____

Nota para el entrevistador
Un sistema permanente se refiere a la existencia de registros sobre la evolución de la situación socioeconómica de un paciente.

14. Si los pobres no tienen que pagar: Cómo se decide(n) quién es pobre:
(a) Investigación socioeconómica _____
(b) Beneficiario bono PRAF _____
(c) Otros _____

(Especifique como) _____
_____
_____
_____
_____
_____

16. Se aplican estos criterios (se hace la determinación de quien es pobre) por:
16a. Cada consulta _____
16b. Sistema permanente _____
16c. Si hay un sistema permanente: Cómo funciona este sistema?
16c1. Se anota en el expediente del paciente? Sí ____ No ____

16c2. Explicar el sistema: _____
_____
_____
_____
_____
_____

Sección VI. Recuperación y Uso de los Fondos durante 1999.

Las siguientes pocas preguntas se enfocarán a la cuantificación de la recaudación de los fondos recuperados, las personas que intervienen y el uso de los mismos.

17.Quién colecta las cuotas?

Persona / Cargo	Sistema Institucional (Señale aquí)	Sistema Comunitario (Señale aquí)
17a El Director		
17b Receptor de fondos		
17c Auxiliar de Enfermería		
17d Enfermera profesional		
17e Medico		
17f Trabajador Social		
17g Comité de Salud		
17h Otro (especifique)		

l7a1. El o la receptora de fondos es empleado de la Secretaría de Salud?

_____ Si _____ No

17a2. Si la respuesta es "No": Quién le paga?

1) Nadie (es voluntario) _____
2) La Municipalidad _____
3) Otra (especifique)_____

18. Cuánto recuperó en 1999, el sistema **institucional**?

Mes	Monto (Lempiras)
Enero	
Febrero	
Marzo	
Abril	

Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	
Total del año	

19. Cuánto recuperó en 1999, el sistema **comunitario**?

Mes	**Monto (Lempiras)**
Enero	
Febrero	
Marzo	
Abril	
Mayo	
Junio	
Julio	
Agosto	
Septiembre	
Octubre	
Noviembre	
Diciembre	
Total del año	

20.Qué se hace con los fondos recuperados del sistema **institucional**:

Que se hace con los fondos del SISTEMA INSTITUCIONAL:	**Todos los fondos recuperados**	**Una parte de los fondos (Indique el porcentaje)**
20a. Se los mantiene en la caja chica mensual		
20b. Se gastan en las necesidades de UPS		
20c. Se los lleva a la Oficina Regional		
20d. Los recoge la Oficina Regional		
20e. Se depositan en una cuenta bancaria		
20f. Otro (Especifique)		
20g. Otro (Especifique)		
20h. Otro (Especifique)		

21. Si los depositan en cuenta bancaria, cuánto es el saldo a la fecha? _____Lempiras.

22. Quién dispone del dinero del sistema institucional?

(a) Director _____
(b) Administrador _____
(c) Receptor de fondos_____
(b) Enfermera _____
(c) Médico _____
(d) Otros (Especifique) _____

23. Qué se hace con los fondos recuperados del sistema **comunitario**:

Que se hace con los fondos del SISTEMA COMUNITARIO:	**Todos los fondos recuperados**	**Una parte de los fondos (Indique el porcentaje)**
23a. Los mantiene en la caja chica		
23b. Los gastan en las necesidades		
23c. Se los lleva a la Oficina Regional		
23d. Se los recoge la Oficina Regional		
23e. Se depositan en una cuenta bancaria		
23f. Se los lleva la Junta o Comité		
23g. Los recoge la Junta o Comité		
23h. Otro (Especifique)		
23i. Otro (Especifique)		

24. Si lo deposita en una cuenta bancaria, cuánto es el saldo a la fecha? _____Lempiras.

25. Quién dispone del dinero del sistema comunitario?

(a) Junta o Comité _____
(b) Tesorero de la Junta _____
(c) Receptor de fondos _____
(d) Enfermera _____
(e) Auxiliar de enfermería _____
(f) Otros (Especifique) _____

Sección VII. Los gastos asociados al manejo del sistema institucional de fondos.

Me gustaría ahora con su ayuda poder cuantificar los gastos asociados al manejo del sistema institucional de fondos, referidos a las actividades, el tiempo y los recursos involucrados en el manejo de dichos fondos.

[Las Preguntas 26 hasta 40 son solo para el sistema institucional]

26. La UPS entrega los fondos recuperados del sistema institucional a la Oficina Regional
(1) Sí ____ (2) No ____

26.a. Si la respuesta es "Sí" con qué frecuencia:

(a) Semanal _____
(b) Mensual _____
(c) Bimensual _____
(d) Trimestral _____
(e) Semestral _____

27. Si la respuesta es " No", favor pasar a la pregunta # 37.

28. Tiene alguien de la UPS que viajar a la Oficina Regional para hacer la entrega de de los fondos recuperados.

(1) Sí ____ 28a. ¿Quién lo hace?_____
(2) No____ 28b. ¿Señale por qué?_____

29. Si la respuesta #28 es "Sí": La persona viaja a la Oficina Regional

(a) Semanal _____
(b) Mensual _____
(c) Bimensual _____
(d) Trimestral _____
(e) Semestral _____

30. La persona que viaja a la oficina regional aprovecha el viaje para hacer otras cosas:

Descripción	Tiempo en Horas	Cada Cuanto
Obtener Cotizaciones		
Hacer Compras con los		

Fondos recuperados		
Entregar Documentos		
Levantar Inventarios		
Otros		

31.A qué distancia se encuentra la Oficina Regional de la UPS?

Distancia: _____ Kms

32. Cuánto tiempo tarda de ida y vuelta? Tiempo: _____ Hrs

33. Normalmente cuánto gasta en el pasaje?

(a) Bus _____Lps.

(b) Nada, vehículo del Estado_____

34. Cuántas personas viajan? _____personas

35. El (ellos) recibe(n) viáticos por su(s) viaje a la Oficina Regional?

Sí_____ No _____

35a. Si la respuesta es "Sí"de dónde sale el pago de viáticos:

(a) Fondos recuperados _____

(b)Presupuesto regional _____

(c) Otros (Especifique) _____

36. Cuál es el salario de las personas que viajan a la Oficina Regional?

36a. Persona (Cargo): _____ Salario mensual _____

36b. Persona (Cargo): _____ Salario mensual _____

36c. Persona (Cargo): _____ Salario mensual _____

37. Cuántas compras hizo la UPS en el último mes (30 días)? _____

38.Cuántas cotizaciones obtuvo la UPS en el último mes (30 días)? _____

39 Cuánto tiempo se utilizó en el último mes (30 días) obteniendo esas cotizaciones (incluyendo tiempo de viaje)? _____ horas

40.Cuánto tiempo fue invertido o cuánto tiempo se utilizó el último mes (30 días) ejecutando las compras (incluyendo tiempo de viaje)? _____ horas

41 Quién determina como se usan los fondos recuperados?

En la primera columna indique con una "X" si la persona participa. Si hay más de una persona en la segunda columna, anote "1" la persona que decide más frecuentemente las decisiones,"2" la persona que decide después de la anterior.

Persona Quien Determina el Uso	**Fondos Institucionales** ***Sí = X***	**Fondos Institucionales** ***Priorización***	**Fondos Comunitarios** ***Sí = X***	**Fondos Comunitarios** ***Priorización***
41a. El Director de la UPS				
41b. El Comité o Junta de Salud				
41c. El Patronato				
41d. La Oficina Regional				
41e. El Administrador				
41f. Contador				
41g Auxiliar de Enfermería				

Especifique la respuesta anterior

_____
_____
_____
_____

Sección VIII. Las formas de organización y participación social.

Como Usted sabe, en la operativización de los sistemas de fondos recuperados participan diversos actores locales. Nos gustaría conocer su opinión sobre ellos.

JUNTA O COMITÉ DE SALUD

42.Hay una Junta o Comité de Salud? (1) Sí ____ (2) No ___

43. Por qué se conformó el Comité?_____

44. Cuándo lo conformaron? _____ (fecha)

45. Cómo lo conformaron?

45.a. Designado_____ 45.a.1. Por quién?_____

45b Elección_____ 45.b.1.Cuándo fue?_____(fecha)

46.Cuántos miembros tiene el Comité? _____

47.La UPS tiene un representante en el Comité? (1) Sí ____ (2) No ____

47a. Si la respuesta es "Sí". Quién? (Cargo)_____

48.Qué actividades realiza el Comité de Salud? [Encierre en un círculo].

a. Reuniones para discutir problemas de salud
b. Reuniones para discutir las actividades de la UPS
c. Comprar insumos para la UPS
d. Mantener la infraestructura física de la UPS
e. Supervisión de los Fondos Recuperados de la UPS
f. Otras (Especifique) _____

_____

_____

_____

_____

49. Cuántas veces se ha reunido en el año 1999?_____Ninguna ____ Veces

Notas para el entrevistador
Interesa fundamentalmente la relación entre la UPS y la Junta o Comité de Salud en el manejo de los fondos. recuperados

50. Cuándo fue la última vez que se reunió el Comité?_____fecha)

PATRONATO O COMITÉ DE APOYO

51.Cuantos Patronatos o Comités de Apoyo existen en su comunidad_____

52. Alguno o varios de los Patronatos cuentan con un Comité de Salud (1) Sí ____(2) No ____

52a. Si la respuesta a #52 es "Sí": Cuántos miembros tiene el Comité_____
Explique:_____
_____

53. La UPS tiene un representante en el Comité? (1) Sí_____(2) No_____

54. Cuáles son las actividades del Comité de Salud del Patronato? [Encierre en un círculo].

a. Reuniones para discutir problemas de salud
b. Reuniones para discutir las actividades del centro
c. Comprar insumos para el centro
d. Mantener la infraestructura física del centro
e. Supervisión de los Fondos Recuperados del Centro de Salud
f. Otras (Especifique) _____
_____
_____
_____
_____

55. Se reunió el Comité de Salud del Patronato durante el año 1999?
(1) Sí ___(2) No ____
56. Cuántas veces se ha reunido en el año 1999? ____ Veces
57. Cuándo fue la última vez que se reunió el Comité?_____Fecha

LA MUNICIPALIDAD

58. El Municipio tiene un Comité de Salud? (1) Sí ____ (2) No ____ (3) No Sabe_____

59. Si la respuesta a #58 es "Sí": Cuáles son las actividades del Comité? [Encierre en un círculo].
a. Reuniones para discutir problemas de salud
b. Reuniones para discutir las actividades del Centro

c. Comprar insumos para el Centro
d. Mantener la infraestructura física del Centro
e. Supervisión de los Fondos Recuperados del Centro
f. Otras (Especifique)

_____

_____

_____

_____

60. El municipio da algún tipo de apoyo a la UPS ?

(1) Sí ____ (2) No ____

61. Si la respuesta a #60 es "Sí": Qué tipo de apoyo? (Indique todo lo que aplica.)

61a. Dinero (efectivo)?

(1) Sí _____ (2) No _____

Si la respuesta es "Sí":

61a.1. Cuánto fue lo que la UPS recibió en el año 1999? _____ Lps

61b. Pagó por bienes y/o la remodelación de la estructura física del Centro?

(1)Sí ____ (2) No _____

Si la respuesta es "Sí":

61.b.1. Cuánto fue el valor de apoyo en el año 1999 _____Lps

61c. Compró materiales para la UPS?

(1) Sí _____ (2) No _____

Si la respuesta es "Sí":

61.c.1. Valor de las compras _____ Lps.

61d. Apoyo Logístico para la UPS (1)

(1) Sí ____ (2) No_____

Si la respuesta es " Sí"

61.d.1 Valor del apoyo recibido _____Lps

61e. Pagó el salario de uno o más empleados quienes trabajan en la UPS?

Si la respuesta es “Sí”:

61.e.1. Indique el número y tipo de empleados y el monto de su salario anual:

(Cargo)_____ Valor (Lps) _____
(Cargo)_____ Valor (Lps) _____
(Cargo)_____ Valor (Lps) _____
(Cargo)_____ Valor (Lps) _____

CABILDOS ABIERTOS

62. Hay cabildos abiertos en la comunidad donde la gente discute las actividades de la UPS ?
(1) Sí ____ (2) No _____(3) No Sabe_____.

63. Si la respuesta es “Sí”: Cuándo fue el último cabildo abierto? _____(Fecha)

64. Qué se discutió sobre salud? _____
_____
_____
_____
_____
_____
_____

65. Han habido discusiones sobre el sistema de recuperación de fondos y sus cuotas de pago en salud? (1) Sí ____ (2) No ___

66. Si la respuesta es “Sí”: ¿Cuándo fue la última vez? _____(Fecha)

67. Qué se discutió? _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Sección IX. Reformas al manual y reglamento de fondos recuperados.

Nos interesa ahora el conocimiento que se tienen sobre la operativización del manual y reglamento de fondos recuperados en salud, como de sus limitantes para mejorar el trabajo diario que realizan. Un par de preguntas sobre ello.

68. Piensa que los procedimientos e instrumentos del uso de los fondos recuperados deben ser reformulados o modificados?

Sí ___ No ____ No sabe _____

Para Usted cuales instrumentos deben ser reformulados ?

(En la primera columna indique con una "X" si es un problema. Si hay más de una respuesta, en la segunda columna indique con "1" lo más importante, "2" lo próximo más importante, etc.)

68a. Procedimientos de compras (100 lempiras para cotizar)	____	____
68b. El techo de 2,000 lempiras de fondos recuperados	____	____
68c. El techo de 1500 lempiras en compras de medicamentos sin una cotización del Almacén Central de Medicinas	____	____
68d. Las consultas que no se pueden cobrar	____	____
68e. Las exoneraciones a los indigentes	____	____
68f. Las exoneraciones a miembros del personal comunitario activo	____	____
68g. Las exoneraciones a empleados de la SS	____	____
68h. Las exoneraciones a miembros de la familia de los empleados de la SS	____	____
68i. El uso exclusivo de bancos estatales para los depósitos	____	____
68j. La no venta de servicios al sector privado	____	____

68k.Otros (Especifique) _____
_____

68l. Otros (Especifique) _____
_____

Sección X. La percepción local sobre el sistema de recuperación de fondos.

Antes que concluyamos, Me gustaría conocer su opinión acerca de.....

69. Cuáles son a su criterio los problemas más importantes que tiene el sistema **institucional** de fondos recuperados?_____
_____
_____
_____

_____

70. Qué podría hacerse para resolver los problemas del sistema **institucional**? Qué sugiere Usted.?.

_____
_____
_____
_____
_____
_____
_____

71. Cuáles son a su criterio los problemas más importantes que tiene el sistema **comunitario** de fondos recuperados?

_____
_____
_____
_____
_____
_____

72. Qué podría hacerse para resolver los problemas del sistema **comunitario**? Qué sugiere Usted?_____

_____
_____
_____
_____

73. Cuáles son a su criterio los problemas más importantes que tiene el sistema mixto de fondos recuperados?._____

_____
_____
_____
_____
_____
_____
_____

74. Qué podría hacerse para resolver los problemas del sistema **mixto**? Qué sugiere Usted?_____

_____

_____
_____
_____

75. Qué piensa Ud. sobre la posibilidad de designar al Alcalde como supervisor del sistema **institucional** en vez de la Oficina Regional?. Justifique porqué:
_____
_____
_____
_____
_____
_____
_____

76.Qué piensa Ud. sobre la posibilidad de establecer un solo sistema de fondos recuperados?
_____
_____
_____
_____
_____
_____
_____

77. Explicar cuál sistema sería y por qué?_____
_____
_____
_____
_____
_____

Gracias por su colaboración

Nombre del Encuestador: _____

SECRETARIA DE SALUD
UNIDAD DE PLANEAMIENTO Y EVALUACION DE LA GESTION (UPEG)
Proyecto PHR/USAID

DIAGNOSTICO DE LOS SISTEMAS DE FONDOS RECUPERADOS

Cuestionario para las Oficinas Regionales

A1. Fecha:___/___/_____ Formulario #2 -- _ _

A2. Region: _____

A3. La persona principal entrevistada: _____

(a) Administrador de la región_____(b) Encargado de recuperación de fondos____

A3a. Número telefónico: (1) _____

1.Hay un manual que explique el manejo del sistema institucional de fondos recuperados?

(1) Si _____

(2) No _____

1a. Si la respuesta es "Si": Pudiera enseñármelo? Tienen una copia _____
No tienen una copia ___

2.En los sistemas institucionales, piensa Ud. que el Reglamento y Manual obstaculizan el uso de los fondos recuperados?

(1) Sí ___ (2) No ____

2a. Si la respuesta es "Sí": Cuales son los obstáculos? (Si hay más de una respuesta, indique con "1" lo más importante, "2" lo próximo más importante, etc.)

2b. Procedimientos de compras (+ de100 lempiras para cotizar) ____
2c. El techo de 2,000 lempiras como fondo rotatorio ____
2d. El techo de 1500 lempiras en compras de medicamentos sin una cotización del Almacén Central de Medicinas ____
2e. Las consultas que no se puede cobrar ____
2f. Las exoneraciones a los indigentes ____
2g. Las exoneraciones a miembros del personal comunitario activo ____
2h. Las exoneraciones a empleados de la SS ____
2i. Las exoneraciones a miembros de la familia de los empleados de la SS ____
2j. Utilizar otros bancos para hacer depósitos _____
2k. Otros (Especifique) _____
_____
2l. Otros (Especifique) _____

3. Todos los CESARes y CESAMOs en esta Región tienen el mismo nivel de cuotas en sus sistemas institucionales? (1) Sí ____ (2) No ____

4. Quién determina el nivel de las cuotas en los sistemas institucionales?
   4a. Las UPSs (cada una de ellas) los determinan ____
   4b. La Oficina Regional (Director de la Región) los determinan _____
   4c. Las UPS hacen sugerencias/propuestas pero la Oficina Regional tenga que autorizar los niveles _____
   4d. Costos establecidos por el manual (Especifique)
   4e. Otro (Especifique) _____
   _____
   4f. Cómo se determinan las cuotas?
   (a) comparación con el sector privado_____
   (b) costos involucrados _____
   (c) sugerencia de otros _____
   (d) otros _____

5. Alguna vez ha cambiado una o más de las cuotas por servicios en la Región?
   (1) Sí ____ (2) No ____

   5a. Cuáles de las UPSs han cambiado sus cuotas?
   5a1. Todos las UPSs _____
   5a2. Solo algunas _____ Cuales?.Señale en la matriz adjunta.

   .

   5b. Cuándo fue la última vez?

   5b2a. En un CESAMO _____(fecha)
   5b2b. En un CESAR _____(fecha)
   5b2c. En un Hospital de Area _____(fecha)
   5b2d. En el Hospital Regional _____(fecha)

   5c. Si la respuesta es "No". Porque no lo hace?
   5c1. El Reglamento no nos da la autoridad para hacerlo _____
   5c2. La Oficina Central no nos da la autoridad para hacerlo____
   5c3 Los gremios no nos permiten hacerlo _____
   5c4 Otros (Especifique)_____
   5c5 Otros (Especifique)_____

6. Hay algunos servicios que son siempre gratis a todo el mundo?. (1) Sí___ (2) No___

7. Si la respuesta # 6 es “Sí”: Cuales son los servicios gratis?.

Servicio	Gratis en todos los Sistemas Institucionales
7a. Consultas prenatales	
7b. Crecimiento y Desarrollo	
7c. Inmunizaciones	
7d. Planificación Familiar	
7e. Enferm. De Trans. Sexual	
7f. Tuberculosis	
7g. Otras (Especifique)	
7h. Otras (Especifique)	
7i. Otras (Especifique)	
7j. Otras (Especifique)	

8. Para los otros servicios (los que no estuvieron mencionada en #7), todos los pacientes tienen que pagar la cuota normal?

   8a. En el sistema institucional: (1) Sí ____ (2) No ____

9. Si la respuesta a #8a es “No”: Quién no tiene que pagar o tienen que pagar solo una parte del cobro normal en el sistema institucional?

Grupos de Personas	No Pagan Nada (Sist. Instit’l)	Pagan Solo Una Parte (Indique el Porcentaje)
9a. Los Pobres (que no pueden pagar)		
9b. Empleados de la Sec. de Salud		
9c. Miembros de la Familia de Empleados de la Secretaría de Salud		
9d. Colaboradores Voluntarios		
9e. Monitoras de Nutrición		
9f. Voluntarios de Salud/Guardianes		
9g. Parteras		
9h. Miembros del Comité o de la Junta de Salud		
910. Médicos		
911. Otros (Especifique quien)		
912. Otros (Especifique quien)		

10.En el sistema institucional: Si los pobres no tienen que pagar, quién determina quienes son los pobres? (Indique todos los que participan en la decisión: Si hay más de una persona, indique con "1" lo más frecuente, con "2" el segundo más frecuente, etc.)

10a. Es definida por reglamento de la Oficina Regional _____
10b. Es la decisión de cada UPS _____
10c. Es la decisión del Comité de Salud _____
10d. Es la decisión del Alcalde _____
10e. Es la decisión del Patronato _____
10f. Otro (Especifique quien) _____

11.Si los pobres no tienen que pagar: Cómo decide(n) quien es pobre:

(a) Investigación Socio-Económica _____
(b) Beneficiarios del Bono Praf_____
(c) Otro (Especifique) _____

11a. Les conoce(n) los pobres_____
11b. Otros (Especifique como) _____
_____
_____
_____

12.Qué hace la región con todos los fondos recuperados del sistema institucional?. Señale en la matriz adjunta el número de UPS de la región?.

12a.Los devuelve a la UPS según lo establece manual _____
12b.Los devuelve a la UPS según otro criterio _____
12c.Apoyan al resto de beneficiarios de la red _____
12d. Otro.
Especifique?_____
_____
_____

13. Que hace la Región con la parte de los fondos recuperados del sistema institucional?. Señala en la matriz adjunta él numero de UPS de la región.
13a. Los devuelve a la UPS según lo establece el manual. _____
13b. Los devuelve a la UPS según otro criterio. _____
13c. Apoyan el resto de beneficiarios de la red _____
13d. Otro
Especifique:_____
_____
_____
_____

14.Que personas manejan el sistema de fondos recuperados en la Oficina Regional? Indique que porcentaje del tiempo completo de cada persona dedicada a trabajar solo en los fondos recuperados y el sueldo mensual de cada persona, incluyendo choferes, el Director y el Administrador (quienes tienen que revisar las cuentas y autorizar los pagos).

Persona	**Porcentaje del Tiempo**	**Sueldo Mensual**
14a		
14b		
14c.		
14d.		
14e.		
14f.		

15 Las UPS cumplen mensualmente con la entrega de los fondos recuperados del sistema institucional a los encargados de la oficina regional?. (1) Si ____ (2) No ____

15a. Si la respuesta a #15 es "No": Con que frecuencia lo hace? (a) semanal _____(b) trimestral _____(c) semestral_____(d) otro _____.

16 Alguien de la Oficina Regional tiene que viajar a las UPS para recoger los fondos recuperados y los talonarios? (1) Sí ____ (2) No ____

16a. Si la respuesta a #16 es "Sí": Indique en la matriz de abajo, el nombre de la UPS que se tiene que visitar, la distancia de la Oficina Regional a la UPS, el número de personas que normalmente viajar a la UPS e indique las personas que reciben viáticos normalmente.

Nombre de la UPS	Distancia (Km)	Tiempo ida y Vuelta		# de Personas que viajan	Reciben Viáticos?	Cuanto Lps.
		Horas	Días			
16a1						
16a2.						
16a3.						
16a4.						
16a5.						
16a6.						
16a7.						

16a8.						
16a9.						
16a10.						

17. En promedio, cuántos días por mes está viajando cada persona para hacer el trabajo relacionado con los fondos recuperados?

17a. Persona: _____ Número de días_____por mes
17b. Persona: _____ Número de días _____por mes
17c. Persona: _____ Número de días _____por mes
17d. Persona: _____ Número de días _____por mes
17e. Persona: _____ Número de días _____por mes
17f. Persona: _____ Número de días _____por mes

18. Si la respuesta a #16 es "Sí": La persona(s) quien(es) viaja(n) de Oficina Regional aprovechan el viaje para hacer otras cosas, como:

Descripción	Tiempo en Horas	Cada Cuanto
Obtener información sobre cotizaciones para los centros		
Supervisar el manejo de los fondos para los centros		
Reabastecer de suministros a las UPS		
Levantar Inventario		

19. Cuánto es el monto que recuperó del 25% de los fondos recuperados?_____Lps.

20.Quién determina como la Oficina Regional usa el 25 % de los fondos recuperados que se obtienen de las UPS:

Persona Quien Determina el Uso	**Fondos Institucionales**
20a. El Director Regional	
20b. El Administrador	

20c. El Contador	
20d. El encargado de recuperación de fondos	
20e. Otra (Especifique)	
20f. Otra (Especifique)	

21. Durante 1999, en que gastó la Oficina Regional los ingresos de los fondos recuperados que recibió de las UPS (es decir el 25% establecido en el manual)

(a) Viáticos _____lempiras
(b) Servicios no personales _____lempiras
(c) Combustible _____lempiras
(d) Medicamentos _____lempiras
(e) Material medico quirugico _____lempiras
(f) Otros (Especifique que y la cantidad de dinero para cada uno)

_____
_____

22. En el año 1999 cómo fue la distribución de estos gastos? Indique el monto destinado a:

a. La Oficina Regional propia Lps.____
b. CESARes de la región Lps.____
c. CESAMOs de la región Lps.____
d. Hospitales de Area Lps.____
e. Hospital de la Región Lps.____
f. Otros Lps.____

23.Cuales son a su criterio los problemas más importantes que tiene el sistema institucional de fondos recuperados?_____

_____
_____
_____
_____

24. Que podría hacerse para resolver los problemas del sistema institucional? Que sugiere Usted?_____
_____
_____
_____
_____

25. Que piensa Usted sobre la posibilidad para tener el Alcalde como supervisor del sistema institucional en vez de la Oficina Regional?

Sistemas Comunitarios.

26.La Oficina Regional tiene alguna participación en el manejo de los sistemas comunitarios?.

(1) Sí _____ (2) No _____

26a Si la respuesta es "Sí": Cuál es la participación?

_____
_____
_____
_____
_____

27.Existe un manual o reglamento que explique el manejo del sistema comunitario de fondos recuperados?. (1) Sí_____ (2) No _____

27a Si la respuesta es "Sí". Pudiera enseñármelo?. Tiene una copia_____
No tiene una copia_____

28. Para los servicios comunitarios todos los pacientes tienen que pagar la cuota normal?.

(1) Sí_____(2) No_____

29. Si la respuesta a # 25 es "No": Cuales tienen que pagar o pagan solo una parte del cobro normal en el sistema comunitario?.

Grupos de Personas	**No Pagan Nada (Sist.Comunit.)**	**Pagan Solo Una Parte (Indique el Porcentaje)**
29a. Los Pobres (que no pueden pagar)		
29b. Empleados de la Sec. de Salud		
29c. Miembros de la Familia de Empleados de la Secretaría de Salud		
29d. Colaboradores Voluntarios		
29e. Monitoras de Nutrición		
29f. Voluntarios de Salud/Guardianes		
29g. Parteras		
29h. Miembros del Comité o de la Junta de Salud		
29i. Médicos		
29j. Otros (Especifique quien)		
29k. Otros (Especifique quien)		

30. Cuáles son a su criterio los problemas más importantes que tiene el sistema comunitario de fondos recuperados?_____

_____
_____
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_____

31. Qué podría hacerse para resolver los problemas del sistema comunitario? Que sugiereUd.?_____

_____
_____
_____

32. Qué piensa Ud. sobre la posibilidad de eliminar el sistema institucional y mantener solo un sistema, el sistema comunitario de fondos recuperados?

_____
_____
_____

Nombre del Encuestador _____

Gracias

DIAGNOSTICO DE LOS SISTEMAS DE FONDOS RECUPERADOS

Cuestionario para los Alcaldes

A**Error! Unknown switch argument.**. Fecha:___/___/_____ For
A**Error! Unknown switch argument.**. Region:
_____
A**Error! Unknown switch argument.**. Departamento:
_____
A4. Area: _____
A5. Comunidad: _____
A6. Nombre de la UPS:_____
A7. La persona principal entrevistada: _____
A7a. Su número telefonico: _____ No hay _____
A8. Nombre del Encuestador: _____

1. Conoce el Sistema de Fondos Recuperados del Centro de Salud?
   (1) Si ___ (2) No ____

2. El Alcalde tiene un comité de salud? (1) Si ____ (2) No ____(=> pregunta #8)

3. Cuándo lo conformaron? _____ (fecha)

4. Cómo lo conformaron? _____
   _____
   _____
   _____

5. Cuántos miembros tiene el Comité? _____

6. La UPS tiene una representante en el Comité? (1) Si ____ (2) No ____

7. Cuáles son las actividades del Comité?
   g. Reuniones para discutir problemas de salud _____
   h. Reuniones para discutir las actividades del centro _____
   i. Comprar insumos para el centro _____

j. Mantener la infrastructura física del centro _____
k. Supervisión de los Fondos Recuperados del Centro de Salud _____
l. Otras (Especifique) _____
_____
_____

8. El Alcalde da algun tipo de apoya al centro de salud? (1) Si ____ (2) No ____

9. Si la respuesta a #8 es "Si": Que tipo de apoya? (Indique todo que aplica.)

9a. Dinero (efectivo)? (1) Si____ (2) No ____
9a1. Si la respuesta es "Si": Cuánto fue la cantidad el centro ha recibido en los 12 meses anteriores? _____ Lempiras

9b. Pagó por bienes o la remodulación de la estructura física del centro?
(1) Si ____ (2) No _____
9b1. Si la respuesta es "Si": Cuánto fue el valor de apoyo en los 12 meses anteriores _____Lempiras

9c. Compró materiales para el centro? (1) Si____ (2) No ____
9c1. Si la respuesta es "Si": Valor de las compras _____ Lps.

9d. Paga el salario de una o más empleados quien trabaja en el centro?
9d1. Si la respuesta es "Si": Indique el número y tipo de empleados y el monton de su salario annual:
_____
_____
_____

CABILDOS ABIERTOS

10. Hay cabildos abiertos en la comunidad donde la gente discutan las actividades del centro de salud? (1) Si ____ (2) No ____(=> pregunta #14)

Si la respuesta es "Si":

11. Cuando fue la última cabildo abierto? _____(Fecha)
12. Qué fue discutido? _____
_____
_____
_____

13. Ha habido discusiones sobre el sistema de recuperación de fondos o los cobros? (1) Si ____ (2) No ___

Si la respuesta es "Si":

13a. Cuándo fue la última vez? _____(Fecha)
13b. Qué fue discutido? _____
_____
_____
_____

PREGUNTAS GENERALES

14.**Error! Unknown switch argument.**Cuáles son a su criterio los problemas más importantes que tiene el sistema institucional de fondos recuperados?_____

_____
_____
_____
_____
_____

15. Qué podría hacerse para resolverlos problemas del sistema institucional? Que sugiere Ud.?_____

_____
_____
_____
_____

16.**Error! Unknown switch argument.**Cuáles son a su criterio los problemas más importantes que tiene el sistema comunitario de fondos recuperados?_____

_____
_____
_____
_____
_____

17. Qué podría hacerse para resolverlos problemas del sistema comunitario? Que sugiere Ud.?_____

_____
_____
_____
_____

18. Qué piensa Ud. sobre la posibilidad para tener el Alcalde como el supervisor del sistema institucional en vez de la Oficina Regional? _____

_____
_____
_____

19. Qué piensa Ud. sobre la posibilidad para eliminar el sistema institucional y para mantener solo un sistema, el sistema comunitario de fondos recuperados?

_____
_____
_____

DIAGNOSTICO DE LOS SISTEMAS DE FONDOS RECUPERADOS

Cuestionario para los Comités de Salud

A1. Fecha:___/___/1999 Formulario #3 -- _ _
A2. Region: _____
A3. Departamento: _____
A4. Area: _____
A5. Comunidad: _____
A6. Nombre de la UPS:_____
A7. La persona principal entrevistada: _____
A7a. Su número telefonico: _____ No hay _____
A8. Nombre del Encuestador: _____

1. Hay un Junta o Comité de Salud? (1) Si ____ (2) No ___(=> pregunta #)
2. Cuándo lo conformaron? _____ (fecha)
3. Cómo lo conformaron? _____
   _____
   _____
   _____
4. Cuántos miembros tiene el Comité? _____
5. Cuál fue el proceso para determinar los miembros?

   5a. Fueron asignado _____ 5a1. Por quién? _____

   5b. Fue una elección _____ 5b1. Cuándo fue? _____(fecha)

   5c. Otra (Especifique) _____
6. La UPS tiene una representante en el Comité? (1) Si ____ (2) No ____

   6a. Si la respuesta es “Si”: El representante tiene el derecho de votar?

   (1) Si ___ (2) No ___

7. Que hace el Comité?

m. Reuniones para discutir problemas de salud _____
n. Reuniones para discutir las actividades del centro _____
o. Comprar insumos para el centro _____
p. Mantener la infrastructura física del centro _____
q. Supervisión de los Fondos Recuperados del Centro de Salud _____
r. Otras (Especifique) _____
_____
_____

8. Se ha reunido el Comité de Salud este año? (1) Si ___ (2) No ___
9. Cuántas veces se ha reunido este año? ____ Veces
10. Cuándo fue la última vez que reunó el Comité? _____ (Fecha)

11. Cuáles son a su criterio los problemas más importantes que tiene el sistema institucional de fondos recuperados?_____
_____
_____
_____
_____
_____

12. Qué podría hacerse para resolverlos problemas del sistema institucional? Que sugiere Ud.?_____
_____
_____
_____
_____

13. Cuáles son a su criterio los problemas más importantes que tiene el sistema comunitario de fondos recuperados?_____
_____
_____
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_____
_____

14. Qué podría hacerse para resolverlos problemas del sistema comunitario? Que sugiere Ud.?_____

_____
_____
_____
_____

15. Qué piensa Ud. sobre la posibilidad para tener el Alcalde como el supervisor del sistema institucional en vez de la Oficina Regional? _____

_____
_____
_____

16. Qué piensa Ud. sobre la posibilidad para eliminar el sistema institucional y para mantener solo un sistema, el sistema comunitario de fondos recuperados?

_____
_____
_____

Annex C: Prices of Services

Table C-1

The Most Common Types of Services

for Which There are Differentiated Institutional User Fees*

Number of Facilities with a Distinct Fee for the Service in Question, by Type of Facility

Ranking	Service	CESARs	CESAMOs	Area Hospitals	Regional Hospitals	National Hospitals	Number of Facilities, All Types Number	% of Top 18	% of All
1	General Consultation	25	65	14	4	5	113	26%	10%
2	Laboratory		15	15	5	5	40	9%	4%
3	Lab: Gravindex		17	13	5	3	38	9%	3%
4	Lab: VDRL		15	13	4	5	37	9%	3%
5	Dental: Extraction		13	11	5	4	33	8%	3%
6	Lab: Blood Chemistry		8	9	4	5	26	6%	2%
7	Specialty Consultation		2	11	4	5	22	5%	2%
8	X-Ray: Thorax			11	3	4	18	4%	2%
9	Dentistry: Cleaning		4	4	4	4	16	4%	1%
10	Pielograma			9	3	3	15	3%	1%
11	X-Ray: Head/Cranium			9	2	2	13	3%	1%
12	Dentistry: Provisional Filling		2	5	2	3	12	3%	1%
13	Birth		2	7	2		11	3%	1%
14	Lab: Complete Blood		2	6	2		10	2%	1%
15	Enema			4	2	2	8	2%	1%
16	Nebulizations			4	2	1	7	2%	1%
17	Legrado			5	2		7	2%	1%
18	Hospitalization: C-section			5	2		7	2%	1%
	Top 18 Services' Total	25	145	155	57	51	433	100%	40%
	Grand Total: Total Number of Services with Distinct Fees in all Facilities	33	181	669	141	97	1088		

Top 18 Services as a Percent of All Services in all Facilities	76%	80%	23%	40%	53%	40%
Number of facilities:	25	66	16	6	6	119
Average No. of Fees per Facility:	1.3	2.7	41.8	23.5	16.2	9.1

Table C-2
Variations in the Prices of the Most Common Types of Services
for Which Institutional User Fees Are Charged in the Four Non-Psychiatric, National Hospitals

Frequency Ranking	Service	Number of Facilities	Minimum	Maximum	Min.Value as a Percent of Max.	Mean	Median	Std. Dev.*
1	General Consultation	4	1	1	100%	1	1	0
2	Specialty Consultation	4	1	1	100%	1	1	0
3	Laboratory	4	1	5	20%	2	1	2
4	Lab: VDRL	4	1	5	20%	2.5	2	1.91
5	Lab: Blood Chemistry	4	1	10	10%	4.25	3	4.27
7	Dentistry: Extraction	2	8	30	27%	19	19	15.56
8	Dentistry: Cleaning	3	10	30	33%	16.7	10	11.55
9	X-Rays: Thorax	3	5	11	45%	8.7	10	3.21
10	Lab: Gravindex	3	1	5	20%	3	3	2
11	Dentisry: Provisional Filling	2	10	20	50%	15	15	7.07
12	Pielogram	2	40	40	100%	40	40	0
	Unweighted Average of the 12 services' ratio of minimum to maximum fee:				44%			

Table C-3

Variations in the Prices of the Most Common Types of Services for Which Institutional User Fees Are Charged in Regional Hospitals

Frequency Ranking	Service	Number of Facilities	Minimum	Maximum	Min.Value as a Percent of Max.	Mean	Median	Std. Dev.*
1	General Consultation	6	1	5	20%	3.2	3.0	1.6
2	Laboratory	5	1	5	20%	3.4	3.0	1.7
3	Lab: Gravindex	5	5	10	50%	7.0	5.0	2.7
4	Dentistry: Extraction	5	5	10	50%	8.0	10.0	2.7
5	Specialty Consultation	4	1	5	20%	2.8	2.5	1.7
6	Lab: VDRL	4	1	10	10%	4.8	4.0	3.9
7	Lab: Blood Chemistry	4	3	10	30%	5.8	5.0	3.0
8	Dentistry: Cleaning	4	15	40	38%	23.8	20.0	11.1
9	X-Rays: Thorax	3	5	25	20%	16.7	20.0	10.4
10	Pielogram	3	30	200	15%	110.0	100.0	85.4
11	Dentistry: Provisional Filling	2	40	50	80%	45.0	45.0	7.1
12	X-rays: Head/Cranium	2	5	20	25%	12.5	12.5	10.6
13	Enema	2	100	200	50%	150.0	150.0	70.7
14	X-Rays: 8 x 10 cm	2	8	30	27%	19.0	19.0	15.6
15	X-Rays: 11 x 14 cm	2	10	40	25%	25.0	25.0	21.2
16	X-Rays: 14 x 17 cm	2	12	50	24%	31.0	31.0	26.9
17	Birth	2	30	200	15%	115.0	115.0	120.2
18	Lab: Complete Hemogram	2	5	5	100%	5.0	5.0	0.0
19	X-Ray: Specialized	2	20	35	57%	27.5	27.5	10.6
20	X-Ray: Dental	2	7	10	70%	8.5	8.5	2.1
21	Scraping	2	60	200	30%	130.0	130.0	99.0
22	Minor Surgery	2	25	25	100%	30.0	30.0	7.1
23	Hospitalization: C-section	2	75	300	25%	187.5	187.5	159.1
24	Observation	2	25	40	63%	32.5	32.5	10.6
25	Dentistry: Filling	2	20	40	50%	30.0	30.0	14.1
26	Nebulizaciones	2	5	10	50%	7.5	7.5	3.5
	Unweighted Average of the 27 services' ratio of minimum to maximum fee:				39%			

Table C-4

Variations in the Prices of the Most Common Types of Services for Which Institutional User Fees Are Charged in Area Hospitals

Data from the 16 Area Hospitals

Frequency Ranking	Service	Number of Facilities	Minimum	Maximum	Min.Value as a Percent of Max.	Mean	Median	Std. Dev.*
1	Cons.General	16	1	10	10%	3.1	2.0	2.44
2	Laboratorio	15	1	15	7%	4.2	3.0	3.28
3	Lab.VDRL	13	3	15	20%	6.3	5.0	3.15
4	Lab.Gravindex	13	2	15	13%	7.0	7.0	3.49
5	Cons.Especializada	11	1	5	20%	2.6	2.0	1.44
6	Odont.Extraccion	11	3	15	20%	7.7	5.0	4.20
7	Rayosx.Placas torax	11	10	30	33%	21.7	20.0	7.60
8	Targeta de salud	10	3	15	20%	7.3	5.0	4.52
9	Lab.Quimico(sanguineo)	9	4	14	29%	7.4	7.0	3.28
10	Rayosx.Craneo	9	25	125	20%	45.0	30.0	33.63
11	Pielograma	9	25	175	14%	68.3	30.0	57.83
12	Electrocardiograma	8	35	100	35%	56.3	50.0	22.48
13	Parto	7	30	75	40%	50.7	50.0	13.05
14	Odont.Obturacion,Amalgama	6	5	35	14%	21.7	22.5	10.80
15	Serie Gastroduodenal	6	20	120	17%	76.3	89.0	38.17
16	Rayosx.Abdomen	6	15	125	12%	43.3	27.5	42.03
17	Rayosx.Placa simple	6	8	125	6%	43.8	30.0	42.10
18	Hemograma completo	6	2	10	20%	5.5	5.0	2.59
19	RA Test.(Factor Reumatoideo)	6	5	15	33%	9.2	10.0	3.76
20	Tipo RH/Tipiaje sanguineo	6	3	7	43%	5.0	5.0	1.26
21	Acido Urico	6	5	10	50%	8.3	9.0	2.07
22	Trigliceridos	6	7	25	28%	11.2	9.0	6.91
23	Glucosa	6	6	10	60%	8.2	8.0	1.60
24	Colesterol	6	6	20	30%	10.2	9.0	5.08
25	Bun o Urea	6	5	10	50%	8.3	9.0	2.07
26	Creatimina	6	5	10	50%	8.3	9.0	2.07

27	Odont.Obturacion,Provisional	5	5	40	13%	23.0	25.0	13.51
28	Odont.Obturacion,Composite	5	5	50	10%	26.0	25.0	17.46
29	Rayosx.Pie	5	10	50	20%	25.0	20.0	15.81
30	Rayosx.Antebrazo	5	10	50	20%	25.0	20.0	15.81
31	Rayosx.Mu¤eca	5	10	50	20%	25.0	20.0	15.81
32	Senos paranasales	5	15	100	15%	44.0	30.0	33.05
33	Ultrasonido	5	20	100	20%	58.0	35.0	38.83
34	Legrado	5	60	250	24%	122.0	100.0	75.71
35	Hospitalizacion(Cesarea)	5	100	300	33%	220.0	300.0	109.54
36	TGP	5	8	15	53%	10.6	10.0	2.61
37	Bilirrubina Totales/Fraccionados	5	5	35	14%	12.6	8.0	12.70
38	Odont.Limpieza	4	5	20	25%	11.3	10.0	6.29
39	Colon por enema	4	20	150	13%	103.8	122.5	57.35
40	Rayosx.Tobillo	4	20	160	13%	40.0	40.0	18.26
41	Cistograma	4	20	120	17%	48.8	27.5	47.68
42	Nebulizaciones	4	5	15	33%	11.3	12.5	4.79
43	Columna dorsal	4	20	30	67%	27.5	30.0	5.00
44	Contenido uterino	4	15	200	8%	76.3	45.0	83.80
45	Hombro	4	10	50	20%	25.0	20.0	17.80
46	Ambulancia	4	20	1100	2%	392.5	225.0	485.34
47	Hospitalizacion	4	45	144	31%	81.0	67.5	43.75
48	Rayosx.Brazo	4	15	100	15%	41.3	25.0	39.66
49	Rayosx.Pierna	4	15	80	19%	41.3	35.0	30.10
50	P.C.R	4	5	10	50%	8.0	8.5	2.45
51	Muslo Femur AP-LAT(Rayos x)	4	15	50	30%	30.0	27.5	14.72
52	TGO	4	10	15	67%	11.3	10.0	2.50
53	Fosfatasa Alcalina	4	6	15	40%	9.5	8.5	4.04
	Unweighted Average of the 53 services' ratio of minimum to maximum fee:				26%			

Table C-5
Variations in the Prices of the Most Common Types of Services for Which Institutional User Fees are Charged in CESAMOs

Data from the 66 CESAMOs with Institutional User Fee Systems

Frequency Ranking	Service	Number of Facilities	Minimum	Maximum	Min.Value as a Percent of Max.	Mean	Median	Std. Dev.*
1	General Consultation	65	1	5	20%	1.8	2	0.79
2	Lab: Gravindex	17	1	15	7%	7.1	8	3.54
3	Health Card	16	3	14	21%	5.9	4	4.11
4	Laboratory	15	1	12	8%	3.5	3	2.88
5	Lab: VDRL	15	1	15	7%	5.1	5	3.4
6	Dental: Extraction	13	2	10	20%	6.6	5	2.81
7	Lab: Blood Chemistry	8	1	10	10%	5.5	5	3.42
8	Cytology	7	2	10	20%	5.7	5	2.56
9	Dental: Cleaning	4	2	10	20%	27.5	27.5	18.48
10	Specialty Consultation	2	1	2	50%	1.5	1.5	0.71
11	Dental: Provisional Filling	2	10	16	63%	13	13	4.24
12	Complete Hemogram	2	2	6	33%	4	4	2.83
	Unweighted Average of the 12 services' ratio of minimum to maximum fee:				23%			

Table C-6
The Most Common Types of Services for Which There are Differentiated Institutional User Fees in Six National Hospitals*

Ranking	Service	*National Hospitals with Fees for this Service* Number	As a % of Top 20 Services	As a % of All Services
1	General Consultation	5	7%	5%
2	Specialty Consultation	5	7%	5%
3	Laboratory	5	7%	5%
4	Lab: VDRL	5	7%	5%
5	Lab: Blood Chemistry	5	7%	5%
6	Electrocardiogram	5	7%	5%
7	Dentistry: Extraction	4	6%	4%
8	Dentistry: Cleaning	4	6%	4%
9	X-Rays: Thorax	4	6%	4%
10	Lab: Gravindex	3	4%	3%
11	Dentisry: Provisional Filling	3	4%	3%
12	Pielogram	3	4%	3%
13	X-Rays: Head/Cranium	2	3%	2%
14	Enema	2	3%	2%
15	Caste: arm	2	3%	2%
16	X-Rays: Lateral	2	3%	2%
17	X-Rays: Abdomen	2	3%	2%
18	X-Rays: Hip	2	3%	2%
19	Ensofagorama	2	3%	2%
20	IGM	2	3%	2%
	Sub-Total	67	100%	69%
Total: All Fees at All 6 National Hospitals		97		100%

Table C-7
The Most Common Types of Services for Which There are Differentiated Institutional User Fees in the Six Regional Hospitals*

Ranking	Service	*Regional Hospitals with Fees for this Service* Number	As a % of Top 14 Services	As a % of All Services
1	Laboratory	5	7%	4%
2	Lab: Gravindex	5	7%	4%
3	Dentistry: Extraction	5	7%	4%
4	General Consultation	4	5%	3%
5	Specialty Consultation	4	5%	3%
6	Lab: VDRL	4	5%	3%
7	Lab: Blood Chemistry	4	5%	3%
8	Dentistry: Cleaning	4	5%	3%
9	X-Rays: Thorax	3	4%	2%
10	Pielogram	3	4%	2%
11	Dentistry: Provisional Filling	2	3%	1%
12	X-rays: Head/Cranium	2	3%	1%
13	Enema	2	3%	1%
14	X-Rays: 8 x 10 cm	2	3%	1%
15	X-Rays: 11 x 14 cm	2	3%	1%
16	X-Rays: 14 x 17 cm	2	3%	1%
17	Outpatient Visit	2	3%	1%
18	X-Rays: Face	2	3%	1%
19	Birth	2	3%	1%
20	Lab: Complete Hemogram	2	3%	1%
21	X-Ray: Specialized	2	3%	1%
22	X-Ray: Dental	2	3%	1%
23	Scraping	2	3%	1%
24	Minor Surgery	2	3%	1%
25	Hospitalization: C-section	2	3%	1%
26	Observation	2	3%	1%
27	Dentistry: Filling	2	3%	1%
	Sub-Total	75	100%	53%
Total: All Fees at All Regional Hospitals		141		100%

Table C-8
The Most Common Types of Services for Which There are Differentiated Institutional User Fees in the 16 Area Hospitals*

Ranking	Service	*Area Hospitals with Fees for this Service* Number	As a % of Top Services	As a % of All Services
1	Laboratorio	15	4%	2%
2	Cons.General	14	4%	2%
3	Lab.VDRL	13	4%	2%
4	Lab.Gravindex	13	4%	2%
5	Cons.Especializada	11	3%	2%
6	Odont.Extraccion	11	3%	2%
7	Rayosx.Placas torax	11	3%	2%
8	Targeta de salud	10	3%	1%
9	Lab.Quimico(sanguineo)	9	3%	1%
10	Rayosx.Craneo	9	3%	1%
11	Pielograma	9	3%	1%
12	Electrocardiograma	8	2%	1%
13	Parto	7	2%	1%
14	Odont.Obturacion,Amalgama	6	2%	1%
15	Serie Gastroduodenal	6	2%	1%
16	Rayosx.Abdomen	6	2%	1%
17	Rayosx.Placa simple	6	2%	1%
18	Hemograma completo	6	2%	1%
19	RA Test.(Factor Reumatoideo)	6	2%	1%
20	Tipo RH/Tipiaje sanguineo	6	2%	1%
21	Acido Urico	6	2%	1%
22	Trigliceridos	6	2%	1%
23	Glucosa	6	2%	1%
24	Colesterol	6	2%	1%
25	Bun o Urea	6	2%	1%
26	Creatimina	6	2%	1%
27	Odont.Obturacion,Provisional	5	1%	1%
28	Odont.Obturacion,Composite	5	1%	1%
29	Rayosx.Pie	5	1%	1%
30	Rayosx.Antebrazo	5	1%	1%
31	Rayosx.Mu¤eca	5	1%	1%
32	Senos paranasales	5	1%	1%
33	Ultrasonido	5	1%	1%
34	Legrado	5	1%	1%
35	Hospitalizacion(Cesarea)	5	1%	1%
36	TGP	5	1%	1%
37	Bilirrubina Totales/Fraccionados	5	1%	1%
38	Odont.Limpieza	4	1%	1%
39	Colon por enema	4	1%	1%
40	Rayosx.Tobillo	4	1%	1%
41	Cistograma	4	1%	1%
42	Consultas externas	4	1%	1%
43	Nebulizaciones	4	1%	1%

44	Columna dorsal	4	1%	1%
45	Contenido uterino	4	1%	1%
46	Hombro	4	1%	1%
47	Ambulancia	4	1%	1%
48	Hospitalizacion	4	1%	1%
49	Rayosx.Brazo	4	1%	1%
50	Rayosx.Pierna	4	1%	1%
51	P.C.R	4	1%	1%
52	Muslo Femur AP-LAT(Rayos x)	4	1%	1%
53	TGO	4	1%	1%
54	Fosfatasa Alcalina	4	1%	1%
	Sub-Total	341	100%	51%
	Total	669		100%

Table C-9
The Most Common Types of Services for Which There are Differentiated Institutional User Fees in CESAMOs*

Ranking	Service	*CESAMOs with Fees for the Identified Service* Number	As a % of Top 14 Services	As a % of All Services
1	General Consultation	65	38%	36%
2	Lab: Gravindex	17	10%	9%
3	Health Card	16	9%	9%
4	Laboratory	15	9%	8%
5	Lab: VDRL	15	9%	8%
6	Dental: Extraction	13	8%	7%
7	Lab: Blood Chemistry	8	5%	4%
8	Cytology	7	4%	4%
9	Dental: Cleaning	4	2%	2%
10	Specialty Consultation	2	1%	1%
11	Dental: Provisional Filling	2	1%	1%
12	Birth	2	1%	1%
13	Complete Hemogram	2	1%	1%
14	IUD insertion	2	1%	1%
	Sub-Total	170	100%	94%
Total:	All Fees at All CESAMOs	181		100%

Annex D: User Fee Revenues

Table D-1: MOH Institutional User Free Revenues by Institutional Source, 199(

CODE	Type of Facility / Name of Institution	1996 Rptd Total	No. of 1996 Reports	1996 Avg. Per Month	1996 Calculated Total	1997 Rptd Total	No. of 1997 Reports	1997 Avg. Per Month	1997 Calculated Total	1998 Rptd Total	No. of 1998 Reports
	NATIONAL HOSPITALS										
1-03-01	ESCUELA	2,949,144	12	245,762	2,949,144	3,629,653	12	302,471	3,629,653	4,951,496	12
1-03-02	TORAX	121,398	5	24,280	291,355	869,186	12	72,432	869,186	590,448	12
1-03-03	SANTA ROSITA	556,379	12	46,365	556,379	571,160	12	47,597	571,160	616,089	12
1-03-17	SAN FELIPE	539,549	12	44,962	539,549	621,707	12	51,809	621,707	1,275,496	12
1-03-18	MARIO MENDOZA	321,620	12	26,802	321,620	482,994	12	40,250	482,994	574,284	12
1-03-22	CATARINO RIVAS	1,488,657	12	124,055	1,488,657	1,511,122	12	125,927	1,511,122	2,235,764	12
	SUB-TOTAL	**5,976,747**	**65**		**6,146,704**	**7,685,822**	**72**		**7,685,822**	**10,243,577**	**72**
	REGIONAL HOSPITALS										
1-03-05	SANTA TERESA	378,343	12	31,529	378,343	342,047	12	28,504	342,047	461,191	12
1-03-06	LEONARDO MARTINEZ	316,011	12	26,334	316,011	478,821	12	39,902	478,821	719,854	12
1-03-09	DEL SUR	503,615	12	41,968	503,615	557,811	11	50,710	608,521	694,311	12
1-03-10	DE OCCIDENTE	274,465	12	22,872	274,465	328,808	12	27,401	328,808	435,265	12
1-03-11	ATLANTIDA	1,069,775	12	89,148	1,069,775	970,284	12	80,857	970,284	1,309,639	12
1-03-13	SAN FRANCISCO	594,152	12	49,513	594,152	697,460	12	58,122	697,460	723,926	12
	SUB-TOTAL	**3,136,361**	**72**		**3,136,361**	**3,375,231**	**71**		**3,425,941**	**4,344,186**	**72**
	AREA HOSPITALS										
1-03-04	GABRIELA ALVAR.	320,655	12	26,721	320,655	351,550	12	29,296	351,550	548,798	12
1-03-20	ROBERTO S. CORDOVA	350,127	12	29,177	350,127	325,742	12	27,145	325,742	373,493	12
1-03-25	LA ESPERANZA	243,913	12	20,326	243,913	213,074	12	17,756	213,074	375,566	12
1-03-07	SANTA BARBARA	318,178	12	26,515	318,178	220,441	12	18,370	220,441	325,486	12
1-03-08	SUBIRANA	142,804	12	11,900	142,804	122,868	12	10,239	122,868	195,041	12
1-03-16	PROGRESO	381,323	12	31,777	381,323	349,455	12	29,121	349,455	500,824	12
1-03-19	PUERTO CORTES	320,811	12	26,734	320,811	339,738	12	28,312	339,738	539,012	12
1-03-28	DE SAN LORENZO	267,418	10	26,742	320,902	301,426	12	25,119	301,426	400,255	12
1-03-21	DE GRACIAS	162,603	12	13,550	162,603	171,073	12	14,256	171,073	235,156	12
1-03-24	SAN MARCOS OCOTEPEQUE	280,871	12	23,406	280,871	197,137	12	16,428	197,137	259,666	12
1-03-12	SALVADOR PARED.	165,720	12	13,810	165,720	132,252	12	11,021	132,252	189,885	12
1-03-14	TELA	354,642	12	29,554	354,642	354,301	12	29,525	354,301	442,591	12
1-03-15	TOCOA	334,123	12	27,844	334,123	391,989	12	32,666	391,989	494,136	12
1-03-26	ROATAN	378,772	12	31,564	378,772	375,696	12	31,308	375,696	353,238	12
1-03-27	DE OLANCHITO	656,285	12	54,690	656,285	432,178	12	36,015	432,178	498,943	12
1-03-23	PUERTO LEMPIRA	122,718	12	10,227	122,718	121,864	12	10,155	121,864	240,026	12
	SUB-TOTAL	**4,800,962**	**190**		**4,854,446**	**4,400,784**	192		**4,400,784**	**5,972,116**	192
	HOSPITAL TOTAL	**13,914,070**	**327**		**14,137,511**	**15,461,838**	**335**		**15,512,548**	**20,559,879**	**336**
	REGIONS										
1-02-09	METROPOLITAN REGION	736,454	12	61,371	736,454	627,092	12	52,258	627,092	722,142	12
1-02-01	REGION Nº 1	260,638	12	21,720	260,638	397,920	12	33,160	397,920	409,152	12
1-02-02	REGION Nº 2	481,337	12	40,111	481,337	586,103	12	48,842	586,103	623,633	12
1-02-03	REGION Nº 3	814,016	10	81,402	976,819	757,111	12	63,093	757,111	726,603	12
1-02-04	REGION Nº 4	329,231	12	27,436	329,231	348,751	12	29,063	348,751	399,085	12
1-02-05	REGION Nº 5	336,987	12	28,082	336,987	417,542	12	34,795	417,542	562,862	12
1-02-06	REGION Nº 6	502,342	12	41,862	502,342	511,407	12	42,617	511,407	484,363	12
1-02-07	REGION Nº 7	130,204	12	10,850	130,204	122,583	12	10,215	122,583	203,111	12
1-02-08	REGION Nº 8	42,955	12	3,580	42,955	53,823	12	4,485	53,823	58,110	12
	REGION TOTAL	**3,634,164**	**106**		**3,796,967**	**3,822,332**	**108**		**3,822,332**	**4,189,061**	**108**
	FOOD CONTROL (METRO)	**480,478**	**12**	**40,040**	480,478		**0**		480,478		**0**
	PHARMACY DIVISION	**1,719,450**	**4**		1,719,450	**2,499,450**	**0**		2,499,450		**0**
	GENERAL TOTAL	**19,748,162**	**449**		**20,134,406**	**21,783,620**	**443**		**22,314,808**	**24,748,940**	**444**

Source: UPEG, SS

Table D-2
Expenditures of MOH Institutional User Fee Revenues
By Type of Expenditure and Institution
1996-1999

Type of Facility / Name of Institution	1996 200	1996 300	1996 400	1996 Total Expds.	1997 200	1997 300	1997 400	1997 Total Expds.	1998 200	1998 300	1998 400	1998 Total Expds.
NATIONAL HOSPITALS												
ESCUELA	396,775	2,444,830	108,283	2,949,888	488,745	2,346,954	229,685	3,065,384	533,123	2,829,754	164,928	3,527,805
TORAX	11,581	53,806		65,387	106,916	170,522	19,123	296,561	90,455	416,029	91,588	598,072
SANTA ROSITA	144,642	375,559	16,567	536,768	102,540	396,077	10,282	508,899	85,524	467,067	13,417	566,008
SAN FELIPE	85,725	292,155	5,356	383,236	188,331	262,480	18,794	469,605	258,595	360,578	78,459	697,632
MARIO MENDOZA	34,507	264,956		299,463	41,518	417,340	471	459,329	20,102	440,831		460,933
CATARINO RIVAS	287,457	342,457	53,449	683,363	308,585	626,518	27,803	962,906	464,121	817,083	49,454	1,330,658
SUB-TOTAL	**960,687**	**3,773,763**	**183,655**	**4,918,105**	**1,236,635**	**4,219,891**	**306,158**	**5,762,684**	**1,451,920**	**5,331,342**	**397,846**	**7,181,108**
REGIONAL HOSPITALS												
SANTA TERESA	62,681	246,778	7,962	317,421	44,309	245,387	0	289,696	115,218	331,948	12,500	459,666
LEON.MARTINES	85,577	182,865	5,014	273,456	19,550	17,000	3,816	40,366	220,372	338,753	8,963	568,088
DEL SUR	117,810	322,173		439,983	166,222	368,765	17,036	552,023	182,755	479,703	60,300	722,758
DE OCCIDENTE	73,093	157,687		230,780	88,144	187,027	16,978	292,149	129,176	190,838	111,676	431,690
ATLANTIDA	391,607	665,437		1,057,044	320,042	558,888	0	878,930	506,745	763,437		1,270,182
SAN FRANCISCO	16,509	388,924		405,433	19,319	647,993	3,420	670,732	95,979	534,040	7,300	637,319
SUB-TOTAL	**747,277**	**1,963,864**	**12,976**	**2,724,117**	**657,586**	**2,025,060**	**41,250**	**2,723,896**	**1,250,245**	**2,638,719**	**200,739**	**4,089,703**
AREA HOSPITALS												
GABRIELA ALVAR.	52,358	277,198	14,032	343,588	66,002	215,353	4,755	286,110	177,294	291,112	18,287	486,693
LA PAZ	105,306	181,553	43,688	330,547	102,564	180,412	7,410	290,386	85,942	201,285	8,650	295,877
LA ESPERANZA	84,818	113,127		197,945	56,528	144,568	0	201,096	100,594	208,962		309,556
SANTA BARBARA	140,611	222,508		363,119	46,859	105,171	375	152,405	83,558	100,467	7,113	191,138
SUBIRANA	31,462	120,353		151,815	50,212	103,595	0	153,807	18,787	51,560		70,347
PROGRESO	119,436	263,794	54,209	437,439	53,500	240,273	1,328	295,101	156,366	425,422	36,817	618,605
PUERTO CORTES	113,955	161,517	16,480	291,952	87,699	186,537	23,704	297,940	138,199	188,522	29,369	356,090
SAN LORENZO	66,423	190,562	7,707	264,692	89,368	232,638	11,215	333,221	144,927	167,565	10,367	322,859
GRACIAS	78,119	49,751		127,870	23,319	4,870	0	28,189	84,908	34,747		119,655
SAN MARCOS OCOTEP.	71,622	88,456		160,078	72,564	50,831	4,985	128,380	72,798	109,139	3,500	185,437
SALVADOR PARED.	38,477	64,309		102,786	276,789	57,365	5,910	340,064	15,954	8,361		24,315
TELA	184,052	471,262		655,314	87,097	229,077	0	316,174	132,180	243,748		375,928
TOCOA	134,288	223,258	7,303	364,849	174,684	187,162	4,024	365,870	212,846	199,108	6,029	417,983
ROATAN	171,067	180,976	45,146	397,189	223,918	184,619	55,836	464,373	150,917	102,627	35,599	289,143
OLANCHITO	0	0		0	0	0		0	0	0		543,283
PUERTO LEMPIRA	60,504	56,239	5,554	122,297	73,836	56,119	729	130,684	127,224	98,229	11,021	236,474
SUB-TOTAL	**1,452,498**	**2,664,863**	**194,119**	**4,311,480**	**1,484,939**	**2,178,590**	**120,271**	**3,783,800**	**1,702,494**	**2,430,854**	**166,752**	**4,843,383**
HOSPITAL TOTAL	**3,160,462**	**8,402,490**	**390,750**	**11,953,702**	**3,379,160**	**8,423,541**	**467,679**	**12,270,380**	**4,404,659**	**10,400,915**	**765,337**	**16,114,194**
REGIONS												
METROPOLITAN REGION	190,846	497,026	42,591	730,463	240,406	368,153	6,308	614,867	294,750	376,286	8,881	679,917
REGION Nº 1	99,504	194,840	7,058	301,402	133,213	192,630	12,664	338,507	151,326	233,098	13,941	398,365
REGION Nº 2	240,299	239,820	3,354	483,473	244,377	263,368	5,970	513,715	366,430	311,463	8,838	686,731
REGION Nº 3	261,682	294,651	43,754	600,087	308,335	319,474	33,261	661,070	195,578	543,837	250	739,665
REGION Nº 4	70,770	282,152	8,624	361,546	109,786	188,623	24,269	322,678	144,146	213,054	21,809	379,009
REGION Nº 5	116,968	149,055	10,400	276,423	194,188	187,203	19,625	401,016	225,205	293,223	5,469	523,897
REGION Nº 6	245,065	107,935	8,811	361,811	81,652	57,744	860	140,256	308,053	134,849	26,938	469,840
REGION Nº 7	21,920	74,996		96,916	0	0	0	0	42,610	141,439		184,049
REGION Nº 8	28,913	15,608	9,121	53,642	29,152	11,370	0	40,522	51,610	14,133		65,743
REGION TOTAL	**1,275,967**	**1,856,083**	**133,713**	**3,265,763**	**1,341,109**	**1,588,565**	**102,957**	**3,032,631**	**1,779,708**	**2,261,382**	**86,126**	**4,127,216**
PHARMACY DIVISION					**24,566**				**0**			
GENERAL TOTAL	**4,436,429**	**10,258,573**	**524,463**	**15,219,465**	**4,744,835**	**10,012,106**	**570,636**	**15,303,011**	**6,184,367**	**12,662,297**	**851,463**	**20,241,410**

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